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THE JOURNAL
OF THE
KANSAS MEDICAL SOCIETY

19519

PUBLISHED MONTHLY BY THE
KANSAS MEDICAL SOCIETY

EDITED BY
WILLIAM E. McVEY, M. D.
UNDER SUPERVISION OF THE COUNCIL

VOLUME XVIII
JANUARY 1918 TO DECEMBER 1918 INCLUSIVE

TOPEKA, KANSAS
1918

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, JANUARY, 1918 No. 1

Sporothrichosis—Report of Case.

RALPH C. HENDERSON, M.D., Erie, Kan.

Read before the Kansas Medical Society at Salina, Kansas, May 2, 3 and 4, 1917.

The first case of sporotrichosis in man was reported by B. R. Schenck in 1898. In May, 1909, William K. Trimble and Frederick W. Shaw reported their very interesting case before this society. Between 1898 and 1910, a period of twelve years, when Richard S. Sutton published his first article on the subject, fifteen cases were reported. At that time Sutton reported his first case. A report of four cases followed this one, and in December, 1910, in his second article in The Journal of the American Medical Association entitled "Sporotrichosis in America," Sutton reported two more cases. In the same publication of November 2, 1912, appeared a most valuable article by William W. Hamburger entitled "Sporotrichosis in Man," with a summary of all cases reported in the United States and a consideration of the clinical varieties and the important factors in the differential diagnosis.

Up until that time fifty-eight cases had been reported. Since then I am able to find reports of but twenty-four, and with the one I am now to report, make in all eighty-three cases reported in the United States since Schenck reported the first one in 1898.

This would lead one to suppose that this disease is comparatively rare, which I hardly believe is true. It seems quite probable that sporotrichosis is a prevalent disease, particularly in the rural and farming districts, and more particularly in the Middle West, and that many chronic ulcerative processes are unrecognized sporotrichosis. It behooves us then to better understand the clinical picture of this condition, so as to make a proper diagnosis, and not treat it surgically, as has frequently been done, causing the patient weeks of unnecessary suffering. The writer pleads guilty to this charge in one case, but never again. In this district we should be particularly interested, because of the eighty-three cases reported sixty-nine were from the Mississippi Valley, and Kansas ranks next to North Dakota in the number of cases: the former with fourteen cases and the latter twenty-two.

Sporotrichosis exists in four clinical varieties as classified by de Beurman: 1—Localized sporotrichosis with sporotrichotic chancre and ascending lymphangitis and local lymphadenitis. 2—Disseminated gummatous sporotrichosis; multiple subcutaneous nodules distributed without systematic arrangement throughout the body; early small, hard, painless, round masses; late small and large soft cold abscesses. No ulceration. 3—Disseminated ulcerative sporotrichosis; multiple polymorphic ulcerations of the nature of tuberculous, syphilitic, ecthymatous, rupial, furuncular lesions or a mixture of these. 4—Extracutaneous sporotrichosis, with localization in mucous membranes, muscles, bones, joints, occular tissues, synovial membranes, kidneys and lungs. The first, or cutaneous, variety is the one generally found in America, there having been reported but four cases other than this, and they were of the extracutaneous form—one of the eye,

one of the kidney, and two of the lungs.

The infection generally follows some slight traumatic lesion of the face or extremities. Superficial ulceration invariably follows the infection. After a few days or weeks, one or more chains of small, hard, and painless nodules develop along the course of the lymphatics draining the part. Later, these soften and break down, and if allowed to go untreated, break through the overlying skin, forming superficial ulcers and fistulæ. These ulcerations are usually very persistent. There is generally no pain, no effect on the general health and no rise of temperature.

The organism responsible for the disease is an aerobic fungus, consisting of a branching septate mycelium from which ovoid bodies, or spores, develop by budding, either from the extremities of lateral or terminal filaments or from the extremities of the threads. It grows well on all ordinary culture media, and the mycelium and spores stain well with the ordinary dyes.

The course of the disease in some of the lower animals differs but little from that in man. The horse, dog, cat, mouse, rat, monkey, and guinea pig are susceptible. K. T. Meyer, who has given this subject a great deal of study, does not think that sporotrichosis is frequently transmitted from these animals to man; that they are more generally passive rather than active carriers, harboring the sporothrix in their mouths and on the skin and hair. The same is also true of birds and fowls. They may carry the organism on their beaks, and thus infect man by their bites. De Beurman has shown that on the bark of trees particularly, and on vegetable matter in general, the sporotricha develop saprophytically.

The following points are helpful in making a differential diagnosis. The occurrance in a rural community. The history of a trauma of the hand, forearm, or leg followed by a slow incubation, insidious onset, and slow infection ascending from the lesion along the course of the lymphatics. The appearance of small, hard, subcutaneous nodules, gradually softening and breaking down, forming superficial ulcers. The long duration of the disease, with little or no pain, no rise of temperature, and general good health. Finally, the cultivation of the organism on artificial media.

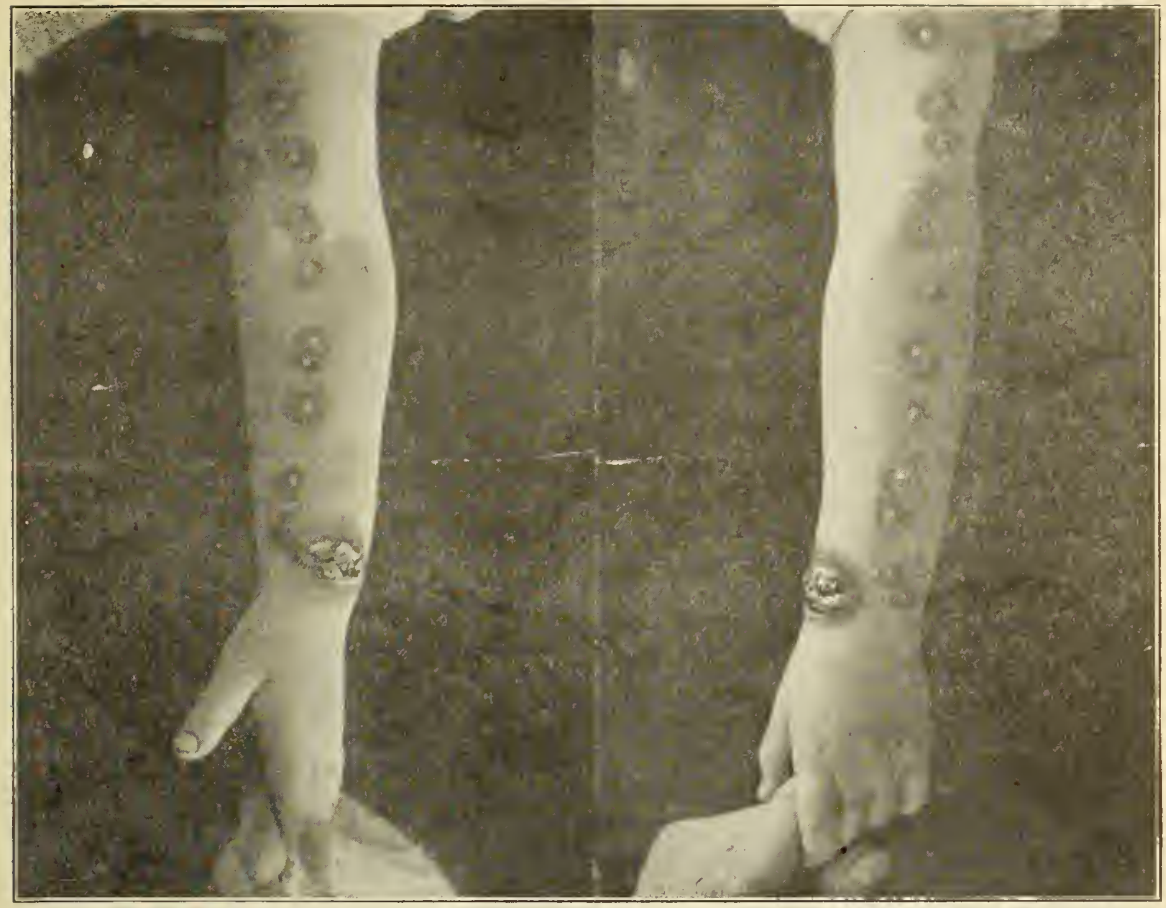
In considering the treatment, there is one thing to remember always: Do not incise the nodules. Apply to them, locally, the tincture of iodine every second or third day. Apply the tincture, also, to the ulcer, and dress with plain gauze. In case the nodules undergo ulceration, treat them the same as the primary lesion. Use no other antiseptics, as they are useless. Give the iodide of potassium, internally, in increasing doses until the tolerance of the patient is reached. If this line of treatment is pursued, no scarring or disfigurement will result.

The following case which has not heretofore been reported is of interest.

Patient—I. T.—Female, age 4, born in Neosho County, Kansas, plump and well nourished. Father, mother, and two sisters living. Cutaneous history of family is negative. History—On June 16, 1916, the family left Sugar City, Colo., traveling overland in a wagon, arriving in Stark, Kansas, on October 20, 1916.

Present Illness.—A short time after their arrival there the child developed a small pimple on the lower extremity of the left forearm about one-half inch above the styloid process and over the external surface of the radius. This began to ulcerate and increase in size. On November 20, 1916, the family moved to Erie, Kansas, and the child was brought to me on December 6, 1916, about four weeks after the pimple first appeared.

The lesion then appeared as a ragged, depressed ulcer, one and one-half inch in length and from one-half to one inch in breadth. The border was raised, edges undermined, and the base was covered with numerous granulations which bled freely when irritated. This ulcer had received no treatment whatever, excepting, on occasional cleansing with warm water by



the mother, and the only protection was that of a clean cloth. In her ignorance of what to do, she did the right thing. No phenol, turpentine, mud poultices, salves, or any of the other numerous domestic remedies had been applied.

The ulcer was clean. No pus or debris whatever. Extending upward from this along the posterior surface of the forearm and arm, on the ulnar side, were twelve nodules, and on the anterior surface were nine nodules, extending up to the axilla; there was also one just above the internal condyle. The axillary and epitrochlear glands were not involved. The nodules were hard, movable, and painless, and about the size of a small cherry. In a few days they began to break down, soften, and turn a purplish color. They were then slightly tender to the touch. They did not ulcerate, neither did I incise them. The patient had no pain nor rise of temperature. She slept well and her appetite was good. She played and romped with the other children as usual, and walked seven blocks to my office every other day during the very cold weather.

A clinical diagnosis of sporotrichosis was made. Bacteriologic Examination. Smears made from the initial lesion, stained with Wright's and Methylene-blue, showed the mycelia and spores, but no pus germs. The lesion being absolutely clean. One of the nodules was aspirated with a sterile syringe and a pure culture of the sporothrix Schenckii obtained. Another one was aspirated and four agar tubes were inoculated. These were incubated at room temperature and, seven days later, pure cultures of the organism had developed on all the slants.

Treatment. — The nodules were not incised. They as well as the initial lesion were painted with the tincture of iodine every other day for three weeks, then every fourth day for the remaining three

weeks. No other local treatment was applied. Potassium iodide was administered three times a day, beginning with 2-grain doses and increasing to 15 grains. On January 17, 1917, the patient was discharged cured, six weeks from the date of the first visit.

Comment.—The origin of this case is uncertain. One of the horses driven from Colorado developed distemper after arriving in Neosho County, but recovered. There were no open sores nor glandular enlargement according to the statement of the father. The other horse was healthy. The children brought a pet rabbit from Colorado, and this, also, appeared to be in a healthy condition. The only explanation of the origin of the infection that seems plausible is that the patient became infected at one of the numerous camping places along the route.

This case, to my mind, is typical of sporotrichosis, in this country, and is attended with several interesting features. First, the age of the patient, she being four years old; there having been but two younger reported, one by Quain, age three years, and the other by Ruediger and Smith, age three and a half years, both females. Second, that no treatment or household remedies had been applied previous to my seeing the case. Third, the clean condition of the initial lesion, no mixed infection. Fourth, smears made from the lesion demonstrated the organism.

The Educational Function of the Hospital.

MAYME CONKLIN, R.N., Topeka, Kan.

Read before Kansas State Hospital Association, May, 1917.

Writing on the subject of education, Herbert Spencer said: "To prepare us for complete living is the function which education has to discharge." The old theory of education was that it was the acquisition of knowledge; the new theory as promulgated by Spencer, is that it is a training of the mental faculties, so that in addition to knowing about things, we are also taught how to accomplish things.

The first duty of the hospitals is, of course, to provide for the care and treatment of its patients; but it also has a function beyond this, and that is educational. In the broadest sense, hospitals may be said to be educational to physicians, medical students, nurses, patients, employes and to the community. While the majority of hospitals are not so located as to be available for students of medicine, all hospitals to a certain extent are educational to the other classes mentioned.

It is unquestionably true that hospitals are becoming each year more and more important factors in the preservation of the public health. There is a constantly growing appreciation of what the hospital means to those who are ill, of its possibilities for educational work and for investigation and research, which while not interfering with the actual care of the patients (the result being quite the contrary), present possibilities of a greater service to mankind generally. The hospital which welcomes teaching within its walls insures more careful methods, more careful study of the individual case and, generally speaking, better and more thorough treatment for its patients.

In this country we have been surprisingly slow to grasp this fact, considering that the growth of the hospital movement has been so rapid. It is quite probable that the rapidity of hospital development in America has been largely responsible for the lack of appreciation of the larger opportunities. It was only a few years ago that the hospital in this country was considered the place of last resort. Today almost a complete reversal of opinion has taken place and it is now considered the place of first resort for anyone who is seriously ill. With this growing appreciation of the value of the hospital, there has occurred a mushroom-like growth of hospitals, attended with all the evils of too rapid development, namely lack of standards or organization and management, lack of standards as to support, poorly formulated plans, mismanagement and failure to

comprehend the greater possibilities of the movement.

Within the last few years, however, there has come a broader conception of what the hospital stands for and of its greater usefulness. This is largely true because of the educational function of the hospital. I have said that the hospital is educational to practically all who live and work within its walls, and to the community as well. Who can doubt that the employes working day after day in such an atmosphere must learn something of value in the way of helpfulness to others, something finer and broader by way of appreciation of life's problems, of human frailties, and of self-sacrificing service to others? Who can doubt that the patients, many of them at least, learn these same lessons and at the same time learn how to take better care of their own bodies and how not to be a source of danger to others? These are phases of the educational function not often considered, but nevertheless important.

Of the more important phases, let us consider the education of medical students. In the so-called teaching hospitals, thousands of medical students are trained each year, both in theory and practice. They are enabled to interview patients and thereby learn how to elicit the necessary information. They are taught what facts to emphasize and what to ignore, what to retain and what to discard. They learn how to examine a patient in order to bring out the abnormal conditions. They learn from the teacher and by actual experience how to recognize a condition and how to reason from the phenomena presented back to the conditions underlying them. Furthermore, having learned at the bedside to recognize abnormal conditions, they learn also what is the proper therapeutic measure, and how to carry it out, which is quite as important. They are taught not only about a thing, but how to perceive the thing itself. The hospital, then, is the training school for thousands of young men, who go forth each year to give to their fellow man the benefit of that knowledge.

Again, every hospital has its resident staff, numbering all the way from one to a hundred. These young men, already recognized as physicians, continue for one or more years to serve the hospital in order to acquire additional skill in diagnosis, in treatment, in operative technique and in powers of observation and reasoning. Then too, there is the senior staff of physicians and surgeons, who by study of the large groups of patience, by the experience gained in operating upon large numbers of patients, acquire a skill and technique which makes them authorities in their subjects and leaders in their profession.

I am aware that I am telling you nothing new, that in fact I am only repeating in a little different form what has been said over and over again. Nevertheless, it seems to me that it bears repetition, for the true value of the hospital, in the broadest sense, is not yet generally recognized.

There remains one, a most important phase of the educational function of the hospital—I might say the most important phase—namely, the education of the nurse. I wish to dwell at some length on this subject, because of the need of a more accurate perception of its possibilities. The training school for nurses represents one of the most important departments of the hospital, both because of its function in nursing the patients and because of the public demand for trained nurses.

Not many training schools for nurses have been started with such a broad conception of the needs, the aims or the value of such a school, as an educational institution. I have said that the growth of the hospital movement has been remarkable. The growth of the nurse training school movement has been equally rapid, for the two have developed together. To this fact we must attribute many of the difficulties which now attend every effort to standardize these schools and to raise the standard of nursing.

To be more explicit, practically every hospital of any size has its training school

for nurses. In the majority of these instances the hospital has established the school, not with any deep-rooted desire to train nurses for the purpose of serving the public generally, or because of any particular interest in education along this or any other line, but with one idea paramount—to get the nursing work of the hospital done in the simplest and cheapest manner possible. Even a superficial study of the situation will convince one that this is not an exaggeration, and that the majority of boards of trustees, medical boards or ladies' committees, have no conception of the great part which the nurse is playing today in all humanitarian work, nor of the inrceased demand for educated, thoroughly trained nurses for all phases of public health work. They think of her only as the pupil and as the private nurse.

Many of these schools — I am almost tempted to say the majority — have standards of admission too low or too elastic, have courses of instruction too meager and too spasmodic, and subordinate too completely the interests of the school, as a school, to the practical needs of the hospital. The point has been made by Mr. Flexner that hospitals owe a duty to medical education, and we heartily agree with him. I would also make the point that hospitals owe a duty to nursing education, and that this is particularly a function of the hospital.

That the trained physician and surgeon play a very important part in the general scheme of life, none will deny. Does anyone believe that the physician and surgeon could begin to do the splendid work which they are doing today without the trained nurse? Without detracting one whit from the credit due the physician and surgeon, we must admit that medical and surgical technique would hardly be what it is today, had it not been for the development of the trained nurse to supplement his work and to assist him in carrying out the complicated and technical procedures of modern practice. That good nursing is often quite as essential as good medical attention, and that it is often equally responsible for a favorable result, none will deny. Furthermore the better trained a pupil is, the better nurse she will be. A nurse cannot be over-trained any more than a physician can be over-trained.

If the hospital owes a duty to medical education, it also owes a duty to nursing education, for the same reason applies, namely, the need of such education in the interest of humanity. Only a few hospitals are available for teaching medical students, while many hospitals can educate nurses, and every hospital large enough to properly support, and which properly conducts a training school, renders a great public service by so doing.

The trained nurse is now called upon to perform work which was never contemplated in the beginning. Even the broadest conception did not in the early days conceive of a service much wider than that of skilled attendance upon the sick. In the present day, however, she is a therapeutic agent of great value. She is called upon in almost every phase of our civic and social life to organize, to systematize and to teach, as the private nurse, the visiting nurse, the school nurse, the health department nurse, the rural nurse, sanitary inspector, etc.

Prof. C. E. A. Winslow, of the College of the City of New York, writing on the education of the public health nurse, says:

We need expert sanitary engineers to build and operate our public works; we need sanitary physicians to deal with the broader communal aspects of the spread of communicable disease; we need sanitary bacteriologists and chemists and statisticians to furnish the special expert knowledge by which all these activities must be guided. More than all, however, we need large bodies of sanitary educators to bring our knowledge to bear on the individual citizen who alone can make so much of it effective. Some of these missionaries of sanitation will be physicians, but most of them will be nurses. And that is why in my judgment the visiting nurse is the most important figure in the

modern movement for the protection of the public health.

Dr. J. H. Mason Knox, late president of the American Association for the Study and Prevention of Infant Mortality, writes as follows:

In the last analysis, however, all our work hinges upon the better care of individual babies coming under our influence, and it is here that the trained nurse should be given first place, both because of her unique opportunities and because of the good results which she has and does accomplish.

The training school for nurses, as well as the medical school, must have the facilities for practical training and actual experience in order that the education may be well rounded and complete. Hospitals exist to serve the public. In the broadest sense, then, the hospital should develop along all lines which tend to public service, which are related to public health, and which do not interfere with its primary purpose. In no other way can it attain its fullest efficiency. There are many hospitals, as we all know, which are now exercising this function. In fact to a greater or lesser extent they all do. There is, however, a need of standards, else there is danger that the profession of nursing will become filled with quacks; that the public will be led to accept poor service when the best is needed; that worthy young women will be misled into believing that they are to receive a thorough training, when they are offered only an imitation and superficial training, for which they must give from one to three years of hard, faithful, honest service; danger that the vast possibilities for public service by a profession of skilled workers may be lost because of the failure to foster the growth of this profession and to protect it from commercialism and low standards.

What are the standards needed? In the first place, it should be recognized that this movement which started out simply to meet a hospital need has developed into an educational movement, in response to a vastly more important and vastly broader need of the public at large. In order to safeguard this movement, therefore, each state should standardize its training schools for nurses, and registration should be compulsory as with the physician.

In order that their graduates may be eligible for registration, schools should be obliged to adopt a fairly uniform curriculum, and to give training in all necessary subjects. Only those hospitals which have more than a minimum number of beds and which are so-called general hospitals, should be recognized as capable of conducting training schools.

Many arguments are heard against such measures, as, for instance, the difficulty of getting a sufficient number of nurses to carry on the work of the hospital, and the need of cheaper nursing service for people of moderate means. With regard to the first, it has not yet been demonstrated that raising the standard of the profession would not attract more applicants to the schools. If such did not prove to be the case, then the training of nurse assistants, or attendants, would undoubtedly meet the situation.

As for the second argument—the need of cheaper service—the same can be said of physicians, yet we are constantly raising the requirements of medical schools and are now considering the desirability of a fifth, or hospital interne year, before allowing the physician to practice. We would not think of recommending half-trained physicians. Then why consider half-trained nurses? The need of hospitals arises partly because of the inability of poor people to employ doctors. Why not consider the hospital as meeting the need for nursing as well? At any rate, if a substitute is needed, let it be found without interfering with the development of, and without lowering the standards of, the nursing profession.

In closing, I wish to repeat that in my opinion it is high time that the medical profession and the public should recognize the importance of high standards in the education of the nurse.

The effect of merely intellectual train-

ing in what is commonly spoken of as "useful knowledge," is too often to make one selfish, self-centered, and too much absorbed in the mere mechanics of education, to the neglect of the education of the heart. Training in a hospital is not confined solely to the intellectual sphere; there is also a training in duty, in genuine altruism, in devotion to others and in self-sacrifice for the public good. "To prepare us for complete living is the function which education has to discharge." To prepare us for broader usefulness in public service is a function which the hospital has to discharge.

Acute Infectious Poliomyelitis.

DR. J. A. RADER, Caney, Kan.

Read before Montgomery County Medical Society at Caney, Kansas, September 21, 1917.

Infantile paralysis should be considered a misnomer, because in the recent epidemic of 1916 in the United States, but mostly in New York City, where there were alone 9,000 cases, numerous cases at sixteen and as old as forty-five were found to have the disease. The statistics of the New York Department of Health show that 80 per cent of the cases were under five years of age, but that the rural cases were of an older age on an average than the urban cases. This is accounted for by the fact that a great number of the urban cases are immunized, and that mild, unrecognized cases—child feeling indisposed a few days, then recovering—are not reported.

The susceptibility of children to poliomyelitis is much less than to the other communicable diseases. In an exposure of 12,146 children only 252 contracted the disease, making a susceptibility of a little over 2 per cent, while in measles 96 per cent contract the disease when exposed, 75 per cent contract whooping cough when exposed, 25 per cent contract scarlet fever when exposed, and 20 per cent contract diphtheria. This susceptibility was further shown in the cases of twins in several families where one would take the disease and the other not. This feature of the disease has been borne out in my experience. One neighborhood in Oklahoma, in five different families, where on an average there were five children in each family, only one in each family had the disease, two children had resulting paralysis in different families. It is thought that the limitation of poliomyelitis in urban epidemics almost entirely to children may be due to the fact that adults had developed a certain degree of immunity, through mild and perhaps unrecognized attacks in their early years, while the persons in more sparsely settled areas had been less exposed to the contagion of the disease in their childhood, but had acquired a degree of immunity which would render them able, as adults, to resist the infection when present in epidemic form. The conclusion is, then, there exists a distinct individual predisposition or susceptibility, and that in New York City they do not expect for several years an epidemic of the disease, because a large percentage of the susceptible children have been attacked or have been immunized by exposure to the disease. A future epidemic could be controlled if we had a method of detecting the 2 per cent of susceptible children and could immunize these against the disease with convalescent serum. It is now generally agreed by the best authorities that the infectious agent is transmitted chiefly by contact with patient or carrier, the usual period of incubation is seven days, but a large number only one, two or three days after exposure.

Out of the maze of uncertainties and wild theories in regard to the specific agencies and the modes of transmission of the disease, which will be soon settled, one point is practically settled and agreed upon by the profession in regard to its treatment and management, and that is that the case of poliomyelitis in its incipiency should be taken to a hospital at once, preferably to the orthopedic, where the cases can get the skill of the best specialists and the equipment for treatment of this disease.

There are four stages in the course of the disease: acute, subacute, convalescent

and chronic. At the Seaside Hospital they are arbitrarily divided. The acute stage covers the first four weeks and corresponds to the active inflammatory process in the cord, and lasts until the cells that have been disabled by effusion have recovered. The subacute stage begins at the fifth week and extends to the time when the cells that have been disabled by light hemorrhage have cleared up. This is placed at the end of four months. The convalescent stage begins at the fifth month and extends to the time when the motor cells that have been disabled by deep hemorrhage have recovered. This should be placed at the end of two years. The chronic stage begins at the third year and represents the permanent paralysis of muscles receiving the nerve supply from the motor cells destroyed by toxemia.

What is the treatment? Complete immobilization of the body in the subacute and possibly in the acute stage, in order to bring a condition of motor cell rest. All treatment of weakened or paralyzed muscles, in whatever part of the body they may be, should be based on the law that a stretched muscle will not regain its tone, and methods and appliances used that will keep the muscles in a position of constant relaxation. If impulses are allowed to enter into a diseased cell that has its outlet blocked, it will either destroy it or cause a more serious condition. Many cases that have not had the immobilization of parts have been found to be due to muscle fatigue and not to true paralysis. Then instead of getting the children up as soon as possible, the opposite course should be pursued. In the convalescent stage muscle training or muscle re-education is valuable with massage. Electricity has no place in the treatment of the disease before the chronic stage, and then its benefits are questionable.

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My Obstetric System.

N. C. SPEER, M.D., Osawatomie.

Read before the Miami County Medical Society.

This paper will consist of my observations on this important branch of medicine. No department of our work in my estimation requires more diplomacy, experience and caution. By diplomacy I might say generalship, which in turn requires assurance, and this in turn requires experience. I believe the young practitioner faces more peril in obstetrics than in any other line.

I have five rules that I observe when entering the lying-in chamber:

First—I know that the kidneys are normal.

Second—See that the heart of the mother is as it should be.

Third—Observe if any sources of infection such as furuncles are in the field of labor.

Fourth—Investigate if any placenta presents in the cervical canal.

Fifth—Learn if the occiput is anterior.

When I know that these points are settled in the affirmative, a feeling of assurance prevails and encouragement can be given to all concerned. Then generalship can be put in practice and care must be exercised.

The generalship consists in conserving the woman's reserve force without meddlesome intervention by digital manipulations.

The care consists of keeping a clean field and clean hands. These may seem commonplace remarks but it is easy to err on first principles.

The first stage being disposed of as experience best teaches, then comes the second stage. I believe this stage calls for almost surgical anesthesia, more conveniently chloroform. In this way the perineal floor is preserved intact and the patient's remembrance of the whole labor seems to be much mollified. About one dozen good pains under general anesthesia after the head has passed the pelvic ring will dilate the most stubborn perineum without wound. I have lowered my perineal casualties to almost nil.

The third stage.—This stage was a source of much annoyance to me until I enlisted the aid of the patient in the expression of the placenta. My plan is this: When there is an after-pain, or semblance

of one, I suggest to them to bear down sharply and, with a moderate Crede, a few contractions suffice. I make gentle traction on the cord even if it is condemned. Practice teaches me it is practical.

I advise cremation of the placenta, instead of the usual and time-honored custom followed in rural districts. I tie the cord with a portion of a one-inch gauze bandage. This proves secure, sanitary and available.

A suggestion with regard to the care of the cord: The nurse is advised to raise the dressing and observe each day that no dermatitis arised about the umbilicus. This accident has proven a source of septic peritonitis in two cases under my observation.

My lying-in bed is prepared in the usual way, and then covered with an Emdeco paper blanket. This is effectual to gather all detritus, especially if gauze is used to receive the excess fluid. When the labor is over simply gather the paper sheet and its contents and place in a common heating stove or furnace and the clearing up is over, the bed is dry, and no mass of bedding to be carted to the laundry room. I use rubber gloves now in every case.

I cleanse the perineal region as follows: Have the patient herself take a soapsuds sitz bath, followed by a 1:2000 cyanide of mercury solution used as a sitz. When the skin is dry, I apply, after the patient retires, a rather free application of Tinct. Iodine U.S.P., over the whole field. I require a freshly laundered sheet to be placed directly over the patient. When I have the Emdeco sheet under them and a clean muslin sheet over them, I feel we are as secure as possible. I have had a very few shaved. I think it is advisable, however.

I keep my patients on their feet or in a rocking chair as long as practical. They often become intractible from being kept out of bed, so concede early in many cases. After dilation is well advanced, I keep the fingers in the parturient canal. I cannot see my way clear to do otherwise.

I preserve the waters at all hazards. I believe they should never be broken. Literally speaking, never. I don't give patients water to drink in active labor. They will invariably vomit or become nauseated. In dystocia with good dilatation I use pituitrin. In severe nervousness I give chloral in small doses. I give morphine and hyoscine hypodermically in those with immoderately severe pain.

In malpositions, except breech, as soon as dilatation has been established I do a podalic version under surgical anesthesia. I have only in one case needed to apply instruments to the after-coming head. I confess to not be able, to my satisfaction, to make an external diagnosis of presentation or deliver a case without examining through the birth canal.

I believe pituitrin will be our aid in post partum hemorrhage. I believe horse serum should be available for those who have lost blood. I believe fully in fl. ext. ergot dram one following labor. I do not believe in the indiscriminate use of forceps — they are largely used as time-savers to physicians. I have applied them twice in a year.

I believe patients should be turned frequently in bed after the second day to prevent retroflexion. I believe no patient should be catheterized, if possible. I don't care how clean it is done. Cystitis is so common, I understand, even in best ordered maternities. A patient can be easily raised slightly in a common wash bowl to get required results.

Protargol 5 per cent protects the baby's eyes.

My observations lead me to say that I average one case of labor a week, that 97 per cent are occiput anterior, that 2 per cent are breech, one 1 per cent mixed varieties.

My further observataions are: A Kelly pad is unsafe and should be condemned; that my infections are usually in cases where there was a laceration of perineum; that the primary repair of cervical lacerations are not satisfactory; that post partum hemorrhage and eclampsia can occur after you have gone and begun to forget that you have had a case of confinement; that infections can occur in supposedly well

organized cases; that pleurisy, typhoid and influenza can occur; that it is unwise to interfere with a uterus if infection has occurred and to not manipulate an embolic infection such as the leg or breast; that it is very wise to inquire for the cause if the after-pains are excessive; that frontal headache has invariably preceded any other symptom of a convulsion and never occurred except in albuminuria; that the limbs of the child are very easily fractured in breech cases—I have had both femur and humerus fractures, they responded well to treatment; that the perineum of an an infant in breech cases can be torn—I saw such a case that a very unintelligent midwife injured, she had a good many hours the start of me; that the sacrum can be partially dislocated by too forcible instrumental interference and give the patient pain for many months; that the pubic bones will separate and give some trouble in locomotion for some time, but fully recover.

I have once before mentioned the following method, in this society, and it met strong condemnation, but I raise the question again.

Indications.—A patient has had annoying and ineffectual pains for several days, has been seen by a doctor several times, given slight hypnotics, chloral, etc., no cessation of pains, no dilatation, and her term of pregnancy is due, I believe to introduce a Barnes bag is a heroic operation, so I, after surgically cleansing the vagina, applying dilute iodine to every surface, fully pack with moist aseptic gauze to bring about dilatation. In two cases I had the very fullest results. The procedure is not original, the idea was gleaned from a maternity hospital report. I do not advise its wide application unless the obstetrician has a fully developed technic for cleanliness.

I believe that the greatest sins of the obstetrician are haste, carelessness and fear. These leave in their wake undue cervical and perineal lacerations and chronic infections.

Follow the scriptural injunction in handling a case of confinement: "Avoid the very appearance of evil." In other words, don't let anything happen, ever so trivial; don't count time as an element; take time, forget that there is anything else to do, for if anything unfavorable occurs no trouble would be too great or road too long to have it effaced.

I have lost more nerve force in apprehension over an elevation of temperature in some of these cases than the cost to me in physical endurance when labor occurred. I would not be averse to this specialty but I wouldn't want to do anything else, for it is somewhat similar to transforming a laborer in the ditch to a finished social leader in a drawing room, to transform a busy practitioner who is a chauffeur, mechanician or hostler into an obstetric attendant and make him fit.

My closing statement is this: I believe it is wise to be entirely frank with all concerned if anything goes wrong.

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Some Uses of Eserine.

CHARLES L. SMITH, M.D., Independence.

Read before the Montgomery County Medical Society, October 19, 1917.

Eserine is a myotic. It produces contraction of the sphincter of the iris by stimulating the endings of the third nerve going to the sphincter and paralyzing the sympathetic fibers to the dilator muscle of the iris (Weeks). It reduces the tension of the eye, but how this is brought about has not been definitely determined. It is used in the strength of one grain to the ounce or one-half to one-fourth as strong. It is sometimes used in solution of two to four times as strong. The stronger solutions often throw the ciliary muscle into spasm, causing very severe pain, which usually lasts about thirty minutes. A certain strength of solution may be used for a time and as the eye becomes better the action on the ciliary muscle becomes greater and it becomes necessary to weaken the solution. It is claimed that cocaine used with eserine prevents the irritation and increases the myotic effect, a weaker solution in the form of an oint-

ment will accomplish the same result.

In the treatment of ulcers of the cornea, atropin is often used to prevent the complications of iritis, to relieve the pain due to the congestion of iris and ciliary body; and thus facilitate recovery. In young patients it is quite uniformly good, but in persons past middle life it may increase the tension of the eye to such a degree that it appears as though the circulation of fluids in the cornea were inhibited as an ulcer will remain stationary for days. The use of eserine even in the presence of iritis is often indicated. The use of eserine 1:1000 or stronger for a few days will cause the ulcer to begin healing. When it has progressed sufficiently the eserine can be discontinued and atropin substituted to combat the iritis. If the iritis is mild, atropin is not always necessary, as small adhesions will become free under eserine.

On the seventh of July, 1916, a man 70 years of age, of good health and rugged appearance, came to me with a large ulcer of left cornea. The eye had been sore for ten days and for a week he had used the treatment of his family physician—atropin drops, argyrol and hot applications. He had not been able to sleep much for several nights. The eye was very red, beefy-looking and quite hard. The ulcer appeared about ready to perforate.

He was immediately put on eserine 1:1000 at frequent intervals with argyrol and hot applications. The pain became easier in a short time and he was able to sleep some that night. This treatment was continued for one week when at evening we changed to atropin because of the iritis, and he had a very poor night, so he was put back on the eserine. This treatment was continued two weeks, till the 29th, when he was dismissed practically well. Before dismissing him the iris was tested and found free although he had had small posterior adhesions.

April 26, 1916, a man 58 years of age, of good health but not very rugged looking, came to the office with a marginal ulcer of the left eye. The ulcer was about 1 by 2½ m.m. at right upper margin. He said he splashed some paint into the eye about two weeks before. He had been using home remedies and the pain had become not extremely severe, but so that he could not sleep. The injection was only moderate, but the tension was greater than in the uninjured eye.

After irrigating with boric acid solution the ulcer was touched up with 4 per cent trichloracitic acid, eserine instilled and later argyrol dropped into the eye and a bandage applied. Eserine was instilled several times daily. At the end of a week he was dismissed well.

In contusion of the eye from blunt objects with or without hemorrhage into the anterior chamber, it is commonly well to instill atropin to quiet the iris and relieve pain. In some of these injuries the eye is thrown into a state of glaucoma. This summer I have had to treat two cases of glaucomatous eye following blows on the eye with a blunt object.

A young man, about 23 years of age, was kicked in the left eye by a colt, July 11. Apparently the toe of the hoof just reached the eye, causing a cut of cornea at lower right quadrant and causing more or less contusion to eyeball. This happened Wednesday and up till Friday he could see all right, he said. He then "had a hemorrhage" in the eye, and a second hemorrhage the following Tuesday night. I saw him on Thursday, ten days after the injury. He had been driving in to his local town, eight miles, to have it treated. He had been using, three times daily, a cleansing solution and some colorless drops.

He was brought to the office and pretty promptly fainted away as I attempted to examine the eye. The eye was badly injected, of stony hardness, anterior chamber filled with blood, and lids swollen. He was very reluctant to go to the hospital, but finally consented to go, but would not permit a paracentesis to be performed to remove the blood from the anterior chamber. He was put on eserine 1:500 or 1:1000 every two hours with hot applications and morphine if needed. He had been given morphine twice daily for several days. He

was given a quarter of morphine only at the office. The eserine gave quite a bit of relief so that he slept some each night. The fourth day he consented to have a paracentesis of the anterior chamber. The blood was evacuated, which gave great relief. About three-fourths of the cornea was so stained with blood that nothing definite could be made out except a widely dilated pupil. Still he could see light and some objects. For several days the pupil remained dilated ad maximum and I gave the opinion that there was paralysis of the iris. After four days the pupil began to contract and at ten days after the paracentesis the upper part and sides of pupil that could be seen were about at normal. The lens could be seen in the pupil. After two weeks in the hospital he went to friends in the city and convalesced for two weeks, mostly in bed. The lens could be seen resting slightly on the pupillary margin of iris below. Against the lens below appeared what I took to be detached retina. He still could see objects through the stained cornea. I was told this week, October 17, that the eye gave no trouble and he still could see some.

Case No. 2, of trauma with blood in anterior chamber: September 29 of this year a boy ten years of age while playing with a sling and small stone struck himself on the side of the nose and the right eye. This was in the forenoon. As he made no special complaint, but little was thought of the accident that day. But he did not sleep well at night and complained of some pain, so his father brought him to me early the next morning. The eye was somewhat injected, tender to touch, with marked increase of tension, and the anterior chamber was two-thirds full of blood. He claimed he could not see objects.

After irrigating with boric acid solution, eserine 1:1000 was instilled. Within ten minutes the boy remarked that the eye felt "better." In about thirty minutes the eye appeared less hard, so eserine was instilled again, a bandage put on and the boy sent home with instructions that eserine be instilled again in two hours. I saw him again four hours later when the tension was perceptibly less. The eserine was continued at two-hour intervals during the day and three-hour intervals at night. The treatment was then made at three-hour intervals during the day and four-hour intervals at night for the following two days. It was then changed to four-hour intervals during the day only. At the end of five days the blood had entirely disappeared from the anterior chamber and at the end of a week there was but a slight injection of the eye to be seen. At the end of two weeks there was no apparent difference between the two eyes and he could read chart as well with the injured eye as with the uninjured one.

That many children lose eyes yearly from injuries is a sad fact. A certain percentage of the loss is due to the treatment or lack of treatment at the time of the injury and a certain percentage is lost by the continued use of a treatment that is not giving results. Eserine is a safe drug to use so far as the tension of the eye is concerned, although it may not be a safe drug to use immediately after a hemorrhage. In a doubtful case, such as just indicated, a mild irrigation with an occluding dressing, and keeping the child quiet in a moderately darkened room for twenty-four hours, would be good treatment.

Hemorrhage occurs more frequently in eyes with increased tension than in eyes with low tension. That the reduction of the tension of an eye will facilitate the growth of tissue is certain. That it may tend to iritis in cases is true, and one must therefore be prepared to treat the possible complications.

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The Hygeia Hospital is now located in its new and larger quarters at 4733 Vincennes Ave., Chicago, Ill. Physicians who wish to refer cases of drug addiction and alcoholism to Dr. W. K. McLaughlin, superintendent, for treatment, should make special note of the new location of the Hygeia Hospital, since the new quarters are located in a section of Chicago very far from the old address.

THE JOURNAL
of The
Kansas Medical Society

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Military Discipline and Medicine

One of the medical officers in one of the training camps was "called down" by a colonel of another regiment when he was seen talking with a group of privates.

The medical department is a very essential part of the army and, while its ultimate purpose is the successful prosecution of this great war campaign, its immediate purposes and those of the strictly military organization are very diverse and their points of view widely separated. The ultimate objective in the training of a military organizaation is the destruction of life, and the more destructive the military machine may be made the more efficient it is for the purpose for which it is intended. In so much as the medical department is able to add to the destructive efficiency, to that extent is it of value, from a strictly military point of view. From this point of view the component elements of the ranks are animated machines which must move with promptness and precision at the officer's word of command, and it is the function of the medical department to keep these machines in perfect running order and to repair all damaged parts as quickly and efficiently as possible. But, from the medical officer's point of view, these are yet men, who have nerves as well as bones and muscles, who have sentiment and perception as well as hearing and eyesight, who may suffer from pain, hunger, thirst and exposure, and whose best service may be hindered by grief, homesickness or disappointment.

Too marked social distinction between the medical officer and the private, too great detachment from the personal welfare of the men, will add nothing to the efficiency of the medical department, but will deprive its officers of important sources of information and will prevent a full appreciation of the personal element in every case of illness or injury.

We have no criticism for military regulations which apply to the strictly military organization, although it is hard to understand how discipline is better maintained by the establishment of arbitrary lines of social distinction, in the National Guard or in the National Army. All men respect the uniform, but the man in the uniform must still earn the respect and confidence of his men. But even the uniforms have become more democratic, with much less distinction between those of the officers and those of the privates than was formerly the case.

The relation of medical officers to the men is very different from that of officers of other departments to the men. Medical officers must sometimes get under the uniform, to the man himself. They will find it extremely difficult to maintain the attitude toward their patients that the line officer prescribes. The relation of the doctor to his patient must be an intimate one, whether he is an officer in the army or in civil life.

There are some officers of the line, high in rank and old in service, who are very democratic and permit a great deal of freedom in their relations with the men. They find no lack of discipline on that account, but are generally regarded as excellent officers. They are big enough to be able to dispense with arbitrary rules for the distinction of officers and men.

Whether the medical officer is big enough to command the respect of the men must be proven in each individual case, but his

duties are not such as to be hampered by free social intercourse with them.

There is nothing in the army regulations to justify such exclusiveness on the part of medical officers, or any other officers, as was required by the colonel in the incident referred to above. It is gratifying to note the attitude of those in supreme command as suggested by the letter of the Secretary of War to the President of the Senate and in which he quotes the following as the only rule or regulation now existing in regard to the relationship between officers and enlisted men:

"Superiors are forbidden to injure those under their authority by tyrannical or capricious conduct or by abusive language. While maintaining discipline and the thorough and prompt performance of military duty, all officers, in dealing with enlisted men, will bear in mind the absolute necessity of so treating them as to preserve their self-respect. Officers will keep in as close touch as possible with the men under their command, will strive to build up such relations of confidence and sympathy as will insure the free approach of their men to them for counsel and assistance. This relationship may be gained and maintained without relaxation of the bonds of discipline and with great benefit to the service as a whole."

Mr. Baker closes his letter with the following observation: "I am still persuaded that in the great army we now have in the field and in training there is a growing realization that it is both possible and useful to be faithful to military discipline and at the same time to the democratic ideals of our country."

It is to be hoped that these rules of segregation will be somewhat relaxed, at least in their application to medical officers, for they must be intolerable to every conscientious physician, especially those who have had some years of practice among the people.

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Camouflage.

Either because they like that sort of thing, or because they are supposed to like it, when it is desired to greatly impress the people with the importance of some proposed movement, it is customary to give them a lot of romance with a few facts when a lot of facts would really answer the purpose much better. Sympathy is frequently the incentive to startling changes of public opinion, but it is worked overtime and it sometimes hides the real merits of a praiseworthy measure. To parade innocence and virtue in dirty thoroughfares in order to create public sympathy may be justified in extreme situations, but seems hardly necessary when the action of an intelligent body of men, such as usually constitute a board of health, is the object to be gained.

Among the items sent out in a publicity campaign conducted by the National Hygienic Society we note the following:

"Today, even, there are few people who know just what prompted the Board of Health to take the step it did.

"A Kansas young woman of irreproachable character returned home from a pleasure tour of travel, recounts the Ladies' Home Journal, to find an ulcer developing on her lip. She went to a doctor who pronounced the ulcer of an unmentionable origin. The girl became inconsolable, and her family, distressed almost to distraction, spared no pains nor expense to ascertain the origin of infection. It was established, beyond reasonable doubt, that the girl's misfortune came from the use of a public drinking cup. The case was brought to the attention of the Kansas Board of Health, with the result that the public drinking cup has been ordered abolished on all railroad trains passing through the state, and from all stations, public schools or public institutions of any kind. It is to be regretted that it required a splendid young woman's misfortune to bring about the action taken, but, at least, she has the satisfaction of knowing that through her misfortune she has doubtless been the means of saving thousands of other innocent victims."

Long before the public drinking cup was officially eliminated in Kansas there were a great many people here, and elsewhere, who found abundant reason for its abolishment in the nauseating filthiness of the thing, but there was also plenty of evidence of its being a disease carrier, if the statements found in numerous text-books at that time are to be so considered.

We have no wish to review the history of the public drinking cup regulations, nor to question the truth of the story related, in most particulars. However, if it is true that the sacrifice of the health and happiness of an innocent young lady was required to prompt the action of the Board of Health in a measure which was so obviously a sanitary necessity, we have misjudged the men who constituted that board. Such a story might have been used in the legislature and would have served an excellent purpose there. Our legislatures are very susceptible to that kind of sentiment.

The point in this story of particular interest to the medical profession is, "It was established, beyond reasonable doubt, that the girl's misfortune came from the use of a public drinking cup." As a matter of scientific interest we would like to know what the evidence was and how the source of infection was positively established. There are many practitioners who have ascribed the specific lesions in their fair patients' mouths to similar sources of infection and have fervently wished for a satisfactory line of evidence to produce.

It is not necessary to prove the guilt of the drinking cup to establish the innocence and virtue of the maiden in the story. It is not even necessary to surmise such a virtuous indiscretion as the osculatory salutation of a sweetheart. Since kissing is such a common practice among the members of the fair sex, both the donor and the recipient of the infection may have been entirely innocent. Physicians have sometimes considered the possible disruption of a family a sufficient justification for misinforming a wife of the nature of secondary specific lesions in her mouth. In other cases the lesions have not seemed to the victim of sufficient importance to require the advice of a physician. Such possibilities are perhaps less common than they have been, but even now must certainly be taken into consideration and regarded as more probable sources of infection than the most public drinking cups.

It would be a considerable task to recall and trace all the kisses a sweet young girl would receive during the time that would elapse between the infection and the appearance of a primary lesion. It would be interesting to know how all the other possible sources of infection were eliminated and the guilt of the dringing cup established.

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Income Tax—A Correction.

Our attention has been called to a statement in the last number of the Journal that "Physicians whose gross annual income exceeds $6,000 are required to pay, in addition to the regular tax and surtax, a special tax of 8 per cent." We are advised that this statement should have been "Physicians whose net income—"

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Every Doctor in the Medical Reserve Corps.

What an ideal situation it would be if every doctor in the United States who is mentally, physically and morally fit, was in this corps.

The time is coming, and in the immediate future, when the medical reserve corps of the army must be immensely augmented, and so as to enable the surgeon general to have at his command for immediate assignment, as conditions demand, a sufficient number of trained medical officers, let us take the above thought seriously.

We all know, from past history, the conserving value of an efficient medical corps, and this means number as well as training.

A statement made by one high in authority in the surgeon general's office that "our fighting forces would be disseminated by sickness and casualties in six months, were it not for an efficient army medical corps," clearly emphasizes the importance of every doctor in the United States, meeting the requirements above referred to, accepting a commission in the Medical Reserve Corps of the United States Army.

The struggle in which we are now engaged, and for which we are preparing to take such a prominent part, depends for its success as much upon the medical pro-

fession as it does upon our combatant forces, and while we do not know that any such intention as herein suggested is in the mind of the surgeon general, it would at least give him the necessary corps of medical officers, upon which to draw, and thus serve the best interests of our country and the best interests of the medical officer serving.

Dr. Weil Dies in Service.

The loss of Major Richard Weil, who died of pneumonia on November 19 at Camp Wheeler, Macon, Ga., will be keenly felt in cancer research work. Dr. Weil was a valued member of the American Society for the Control of Cancer. He gave up his work, before war was declared by the United States, to enlist in the service, and was assigned after his training, as Chief of Staff of the Medical Reserve Corps at Camp Wheeler. Dr. Weil was prominent in the work for cancer research at the General Memorial Hospital and was Assistant Director of the cancer laboratories of Cornell University Medical College in New York.

Supplying 3,617 Hospitals.

When the American Distributing Service became the Medical Supplies Service of the Red Cross there were 3,190 hospitals on its lists, situated all over France, but most numerous in the departments back of the front. A hundred new hospitals are added every month, and at the present time there are 3,617 in 1,356 towns. The work in hospital supplies heretofore done by the American Clearing House and the American Fund for French Wounded will be carried forward through this single service.

Under the Red Cross the funds available have been more than doubled. Heretofore, a hospital was given perhaps half the supplies it asked for, now it is given perhaps three-fourths, the French to supply the remainder. Moreover, the service can give more expensive equipment, such as radiographic installations, sterilizing outfits, and the special instruments needed by surgeons at the central hospitals, much more delicate and costly than those called for in the field service. Two-thirds of the appropriation is consumed in routine supplies secured through the Red Cross purchasing section, and one-third direct in the purchase of special instruments and the like. Everything which can be bought in France is bought here, either through commercial channels or from French workrooms employing refugees or crippled soldiers. A three-story garage is used as the main packing and distributing center, and the physical work is done not by volunteers but by convalescents who live and sleep at the Paris hospitals and are paid for the work they do here in the daytime, so that in this way two good ends are served. During July and August the service shipped material to 2,225 hospitals in 5,563 packages weighing 124,158 kilos. The organization has tripled in size since the Red Cross took hold of it.

Our Honor Roll.

We are again publishing the list of members of the Society now in the army service. We have made such corrections and additions as have been furnished. The list is still incomplete and we will be most grateful for any further information—additional names, corrections in rank or assignments. We are particularly desirous of having the correct addresses of these officers. Few of the county secretaries are able to supply full and definite information and we sincerely hope that any reader of the Journal who is able to supply any information along this line will do so.

Allen County Society—
- Lieut. O. L. Garlinghouse, M.R.C. (Iola).
- Lieut. H. M. Webb, M.R.C. (Humboldt).
- Lieut. J. I. Simpson, M.R.C. (Moran).
- Lieut. J. S. Sutcliff, M.R.C. (Iola).

Atchison County Society—
- Lieut. W. F. Smith (Atchison), M.R.C., Ft. Riley.
- Lieut. S. M. Myers (Potter), M.R.C.
- Lieut. T. E. Horner (Atchison), M.R.C.
- W. K. Fast (Atchison), applied.
- C. W. Robinson (Atchison), applied.

Anderson County Society—
- Lieut. T. A. Hood (Garnett), M.R.C., Ft. Riley.
- Lieut. A. B. Cullum (Garnett), M.R.C., Ft. Riley.
- A. J. Turner (Garnett), applied.
- L. D. Mills (Greeley), applied.
- D. L. Heidrick (Welda), applied.

C. A. Forsythe (Lone Elm), applied.
W. J. Hatfield (Colony), applied.
J. A. Milligan (Garnett), applied.
D. L. Simmons, applied.

Brown County Society—
Capt. W. C. Palmer (Hiawatha), U. S. Inf., Camp Funston.
Lieut. H. L. Goss (Horton), M.R.C.
Lieut. J. S. Rushton (Morrill), M.R.C.
Lieut. H. J. Harker (Horton).

Barton County Society—No report.

Butler County Society—No report.

Bourbon County Society—
Lieut. J. E. Lardner (Fort Scott), M.R.C., Camp Funston.
Lieut. G. S. Lambeth (Bronson), M.R.C., "Somewhere in France."
Capt. J. F. McGill (Fort Scott), M.R.C., Fort Leavenworth.
Lieut. J. R. Brinkley (Fulton), M.R.C., relieved.

Crawford County Society—No report.

Central Kansas Society—No report.

Cloud County Society—
Lieut. M. L. Belot (Clyde), M.R.C., Camp Funston.
Lieut. F. J. Moffatt (Clyde), M.R.C., School of Roentgenology, Kansas City.
R. J. McLaughlin (Clyde), applied.
Lieut. L. E. Haughey (Concordia), M.R.C., Ft. Riley.
Lieut. Ross E. Weaver (Concordia), M. R. C., Ft. Riley.

Cowley County Society—
Lieut. E. H. Clayton (Winfield), M.R.C.,A.S.S.C., Vancouver Barracks, Washington.
Lieut. Walter P. Guy (Winfield), M.R.C., Camp Funston.
Capt. Chas. Hawk (Winfield), M.R.C., Ambulance Co., Ft. Riley.
Lieut. Jones (Winfield), M.R.C.
Lieut. R. Claude Young (Winfield), M.R.C., San Antonio, Texas.
Capt. Milton K. Hawn (Winfield), M.R.C., Hot Springs, Ark.
N. B. Fall (Geuda), applied.

Chautauqua County Society—No report.

Clay County Society—No report.

Cherokee County Society—
Lieut. H. H. Brookhart (Columbus), M.R.C.

Coffey County Society—
Lieut. D. W. Manson (Burlington), M.R.C., Fort Riley.
Capt. M. L. Stockton (Gridley), M.R.C., Fort Riley
Lieut. C. C. Culver (Burlington), M.R.C.
Major H. T. Salisbury (Burlington), M.C.,U.S.N.G., Camp Doniphan.
Lieut. F. C. Boggs (Waverly), M.C.,U.S.N.G., Field Hospital, Camp Doniphan.
Lieut. S. A. McCool (Neosho Falls), M.R.C., Fort Riley.
H. G. Herring (Leroy), applied.

Doniphan County Society—
Lieut. W. A. Gartner (Troy), M.R.C., Fort Riley.
Asst. Surg. H. R. Boone (Highland), U.S.N.M.F., U.S.S. Brutus.

Dickinson County Society—
Lieut. Chas. A. Dieter (Hope), M.R.C.
Lieut. A. E. Harrison (Herington), M.C.,U.S.N.G.
Lieut. D. O. Jackson (Manchester), M.C.,U.S.N.G., Camp Doniphan.
Lieut. H. W. Wright (Enterprise), M.R.C.
W. S. Moore (Longford), passed for commission.

Decatur-Norton County Society—
Lieut. C. W. Cole (Norton), M.R.C., Camp Beauregard, Alexander, La.
Lieut. F. D. Kennedy (Norton), M.R.C., Ft. Leavenworth.

Douglas County Society—
Lieut Mark Beach (Clinton), Ft. Riley.
Lieut. E. R. Kieth (Lawrence), relieved.
Capt. H. L. Chambers (Lawrence), Ft. Riley.
Lieut. R. E. Barnes (Lawrence).
Maj. Carl Phillips (Lawrence), Camp Doniphan.

Elk County Society—No report.

Franklin County Society—
Lieut. Geo. W. Davis (Ottawa), M.R.C., 11th U. S. Cav. Remount Station, Camp Pike, Little Rock, Ark.
Asst. Surg. W. T. Brown (Williamsburg), U.S.N.R.F., 617 Common St., New Orleans, La.
Lieut. C. C. Bennett (Rantoul), M.C., 187th U.S. Inf., Camp Doniphan.
Lieut. Alexander Haggart (Ottawa), M.R.C., Fort Riley.
Lieut. D. H. Smith (Richmond), M.R.C.

Geary County Society—
Capt. W. A. Carr (Junction City), M.R.C., Sanitary Dept., Camp Funston.
Major F. W. O'Donnell (Junction City), M.R.C., Depot Brigade 89th Division N. A., Camp Funston.
Capt. L. S. Steadman (Junction City), M.R.C.

Harvey County Society—
Lieut. R. Hertzler (Newton), M.R.C., 23d U. S. Inf., Postmaster, N. Y.
Lieut. H. H. Hudson (Newton), M.R.C., Camp Doniphan.
Capt. J. R. Scott (Newton), M.R.C., Ft. Riley.
Lieut. H. M. Glover (Newton), M.R.C., 1st Kansas Ambulance Co., 110th Sanitary Train, Camp Doniphan.
Lieut. R. H. Hartman (Newton), M.R.C., 1st Kansas Ambulance Co., 110th Sanitary Train, Camp Doniphan.
Lieut. L. T. Smith (Newton), M.R.C., inactive list.

Harper County Society—
Capt. B. F. Hawl (Anthony), M.R.C.
Lieut. Chas. B. Stephens (Waldron), M.R.C.
Lieut. C. E. Pessler (Anthony), relieved.

Jefferson County Society—
Lieut. Frank Shaeffer (McLouth), Ft. Riley.
Lieut. A. L. Weisgerber (Perry), M. R. C., Camp Logan.

Johnson County Society—No report.

Jackson County Society—
Capt. Chas. M. Sevier (Holton), M.C.,U.S.N.G.
Lieut. Joseph Adams (Soldier), M.R.C.
Lieut. T. M. Greenwood (Circleville), M.R.C.
Capt. W. L. Wilmoth (Dennison), M.R.C.
Lieut. C. J. Bliss (Mayetta), M.R.C.
Lieut. J. E. McManus (Havensville), M.R.C.

Jewell County Society—No report.

Kingman County Society—No report.

Leavenworth County Society—
Capt. C. J. McGee (Leavenworth), Co. 11, M.O.T.C., Fort Riley.
Capt. J. H. Langworthy (Leavenworth), M.R.C., Ft. Leavenworth.
Lieut. C. E. Brown (Leavenworth), M.R.C., Fort Leavenworth.
Lieut. F. B. Taylor (Leavenworth), M.R.C., Fort Leavenworth.
Lieut. P. B. Matz (Leavenworth), M.R.C., Fort Sam Houston, Texas.
Lieut. A. R. Adams (Easton), M.R.C.

Lincoln County Society—No report.

Labette County Society—
Lieut. R. M. Bennett (Mound Valley), M.R.C.
Lieut. A. R. Nash (Parsons), M.R.C., Camp Funston.
Capt. P. Christman (Parsons), M.R.C., Camp Funston.
Lieut. J. C. Cornell (Parsons), M.C.,U.S.N.G., Field Hospital No. 2, Fort Sill, Okla.
Lieut. E. A. Lodge (Parsons), M.C.,U.S.A.

Lyon CountySociety—
Lieut. C. C. Harvey (Emporia), St. Louis.

Lieut. G. B. Brickell (Americus), Ft. Riley.
Capt. E. E. Haynes (Madison), Ft. Riley.
Linn County Society—No report.
Marshall County Society—
Lieut. E. L. Wilson (Marysville), M.R.C.
Capt. G. I. Thatcher (Blue Rapids), M.R.C.
McPherson County Society—
Lieut. A. Engberg (McPherson), M.R.C., New Mexico.
Lieut. S. N. Malfisson (Canton), M.R.C.
Miami County Society—
Lieut. F. L. McDaniel (Osawatomie), U.S.N.M.F., U.S.S. Balsh.
Lieut. B. F. Fraser (Osawatomie), U.S.M.C., Army Medical School.
Marion County Society—
Lieut. J. F. Coffman (Marion), M.C.U.S.N.G., Camp Doniphan.
Capt. E. B. Johnson (Peabody), M.R.C., Ft. Ben Harrison.
Lieut. H. Brunig (Hillsboro), M.R.C., Camp Funston.
Lieut. L. S. Wagar (Florence), M.R.C., Camp Funston.
Lieut. Clyde Appleby (Peabody), M.R.C., relieved.
Lieut. James Welsh (Herington), M.R.C., Base Hospital, Ft. Riley.
Mitchell County Society—
Lieut. K. P. Mason (Cawker City), M.R.C., Co. 13, Camp Funston.
Montgomery County Society—
Lieut. S. A. Alford (Independence), M.C.,U.S.N.G., Fort Riley.
Lieut. W. G. Norman (Cherryvale), M.R.C., Fort Riley.
Lieut. I. B. Chadwick (Tyro), M.R.C., Fort Riley.
Lieut. Thos. Matlock (Coffeyville), M.R.C.. Chicago, Ill.
Morris County Society—No report.
Nemaha County Society—
Capt. F. F. Carter (Seneca), inactive list.
Lieut. C. E. Toll (Seneca).
Lieut. W. H. Heuschele (Corning).
Lieut. J. C. Maxson (Corning).
Lieut. P. V. Annadown (Centralia).
Lieut. W. G. Bouse (Centralia).
Lieut. S. M. Hibbard (Sabetha).
Neosho County Society—No report.
Osage County Society—No report.
Osborne County Society—
Lieut. E. A. Drake (Natoma), M.R.C.
Pawnee County Society—No report.
Pratt County Society—
Lieut. J. R. Campbell (Coats), M.R.C.
Capt. H. Atkins (Pratt), M.R.C., Fort Riley.
C. E. Martin (Cullison), applied.
Republic County Society—
Lieut. C. V. Haggman (Scandia), M.R.C., Ft. Riley.
J. W. West (Narka), applied.
Rice County Society—
Lieut. Marion Truehart (Sterling), Douglass, N. M.
Reno County Society—
Lieut. L. A. Clary (Hutchinson), Hawaii.
Capt. H. L. Scales (Hutchinson), Ft. Riley.
Lieut. W. L. Mundell (Hutchinson), Camp Funston.
Lieut. N. A. Seehorn (Hutchinson), Camp Pike.
Maj. C. S. Evans (Hutchinson), Camp Doniphan.
Lieut. L. J. Beyer (Hutchinson), inactive list.
Lieut. E. C. Taylor (Pretty Prairie).
Lieut. R. W. Springer (Pretty Prairie).
Lieut. W. H. Kirkpatrick (Haven).
Lieut. W. C. Bundurant (Partridge).
Lieut. James Ungles (Langdon).
G. A. Blasdel (Hutchinson), applied.
G. R. Gage (Hutchinson), applied.
Riley County Society—
Lieut. R. R. Cave (Manhattan), M.C.U.S., "Somewhere in France."
Stafford County Society—
Lieut. C. S. Adams (St. John), M.R.C., Camp Funston.
Capt. J. C. Butler (Stafford), M.R.C., Camp Funston.
Lieut. O. Liston (Hudson), M.R.C., Camp Funston.
Lieut. J. A. H. Webb (Stafford), M.R.C., Camp Funston.
Sedgwick County Society—
Lieut. W. I. Mitchell (Wichita), M.R.C., Ft. Riley.
Lieut. G. K. Purvis (Wichita), M.R.C., Ft. Riley.
Lieut. W. A. Phares (Wichita), M.R.C., Ft. Riley.
Lieut. W. R. Greening (Wichita), M.R.C., Ft. Riley.
Capt. L. M. Metassarin (Wichita), M.R.C., Ft. Riley.
Lieut. R. W. Hissem (Wichita), M.R.C., Ft. Riley.
Lieut. W. T. Doherty (Wichita), M.R.C., Ft. Riley.
Lieut. R. O. Logsdon (Wichita), M.R.C., Ft. Oglethorpe.
Lieut. R. A. Dart (Wichita), M.C., U.S.A.
Sumner County Society—
Capt. J. S. Rudolph (Belle Plaine), Ft. Oglethorpe.
Lieut. D. E. Kessicker (Caldwell), Ft. Riley.
Lieut. J. C. McKinnon (Caldwell), Ft. Riley.
Lieut. Clyde M. Zink (Wellington), Amb. Corps No. 2, Camp Taylor.
Smith County Society—
Lieut. V. E. Watts (Smith Center), M.R.C. (commission received).
Southwest Kansas Society—
Lieut. R. T. Nichols (Liberal), M.R.C., Ft. Riley.
Lieut. A. L. Knisely (Liberal), M.R.C., Camp Bowie, Fort Worth, Texas.
Lieut. B. H. Day (Hugoton), M.R.C., Fort Riley.
Lieut. Jas. Donnell (Kinsley), M.R.C., relieved.
Saline County Society—
Major J. D. Riddell (Salina), M.R.C., Ft. Riley.
Lieut. C. M. Fitzpatrick (Salina), M.R.C., Dept. of Roentgenology, Fort Des Moines, Iowa.
Lieut. J. W. Neptune (Salina), M.R.C.
Capt. A. L. Cludas (Minneapolis), M.R.C., Ft. Riley.
Others from Eighth District—
Lieut. F. E. Harvey (Minneapolis), M.R.C., Ft. Riley.
Lieut. G. M. Anderson (Lincoln), M.R.C., Ft. Riley.
Lieut. Malcolm Newlon (Lincoln), M.R.C., Ft. Riley.
F. S. Hawks (Russell).
J. M. Downs (Ellsworth).
Shawnee County Society—
Major S. A. Hammel (Topeka), M.C.,U.S.N.G., Field Hospital, Ft. Sill.
Capt. C. H. Lerrigo (Topeka), M.R.C., Ambulance Co., Camp Pike.
Capt. S. A. Millard (Topeka), M.R.C., Camp Mills.
Capt. A. K. Owen (Topeka), M.R.C., Ft. Riley.
Lieut. C. C. Lull (Topeka), M.C., 130th F.A.,U.S.N.G., Camp Doniphan.
Lieut. M. K. Lindsay (Topeka), M.C.,U.S.A., Camp Funston.
Lieut. H. K. Rogers (Topeka), M.C., Field Hosp., U.S.N.G., Fort Sill.
Lieut. J. A. Crabb (Topeka), M.R.C., Ambulance Co. 44, Camp Pike.
Lieut. A. M. Dawson (Topeka), M.R.C., Ambulance Co. 44. Camp Pike.
Lieut. J. D. Cook (Topeka), M.R.C., in training at St. Louis.
Lieut. F. J. Ernst (Topeka), M.R.C., Ft. Riley.
Lieut. C. M. Hensley (Topeka), M.R.C., Ft. Riley.
Lieut. J. G. Stewart (Topeka), M.R.C., Ft. Sam Houston.
Lieut. E. G. Brown (Topeka), M.R.C., Ist Colorado Inf., Camp Kearny, Cal.
Lieut. L. C. Bishop (Topeka), M.R.C., special duty as alienist.
Lieut. G. E. Hesner (Topeka), M.R.C., special duty as alienist.
Lieut. F. L. Loveland (Topeka), M.R.C., special duty, Hattiesburg, Miss.

Lieut. L. M. Tomlinson (Harveyville), M.R.C., Ft. Riley.
Lieut. A. L. Weisgerber (Perry), M.R.C., Ft. Riley.
Lieut. G. V. Allen (Topeka), M.R.C., inactive list.
Lieut. W. K. Hobart (Topeka), M.R.C., Ft. Riley.
Lieut. O. L. Erickson (Topeka), M.R.C., Ft. Riley.
Tri-County Society—
Lieut. C. M. Miller (Oakley), M.R.C.
Lieut. G. Winslow (Grainfield), M.R.C.
Lieut. W. J. Lewis (Colby), M.R.C.
Washington County Society—
Major H. D. Smith (Washington), M.C.,U.S.N.G., Fort Sill.
Lieut. G. A. Tooley (Washington), M.R.C., Scofield Barracks, Hawaii.
Lieut. H. B. Hawthorne (Palmer), M.R.C., Ft. Riley.
Lieut. M. H. Horn (Morrowville), M.R.C.
Wyandotte County Society—
Lieut. Geo. M. Gray (Kansas City), M.R.C., Advisor to Governor.
Lieut. L. D. Mabie (Kansas City), M.R.C., inactive list.
Lieut. G. H. L. Hamilton (Kansas City).
Capt. C. C. Nesselrode (Kansas City), M.R.C., inactive list.
Lieut. G. H. McGonigal (Kansas City), M.R.C.
Lieut. W. O. Querring (Kansas City), M.R.C., inactive list.
Capt. J. S. Milne (Kansas City), M.R.C.
Lieut. Thomas Richmond (Kansas City), M.R.C., inactive list.
Pasquale Romeo (Kansas City), Italian army.
Capt. L. B. Spake (Kansas City), M.R.C.
Lieut. R. L. Speck (Kansas City), M.R.C.
Lieut. E. A. Sharp (Kansas City), M.R.C.
Lieut. R. W. Layton (Kansas City), M.R.C.
Lieut. H. W. King (Kansas City), M.R.C.
Fred Candler (Kansas City), applied.
J. F. Hassig (Kansas City), applied.
J. W. May (Kansas City), applied.
Lieut. C. E. Mangun (Kansas City), M.R.C., relieved.

SOCIETY NOTES.

DECATUR-NORTON COUNTY SOCIETY.

The Decatur-Norton County Medical Society held its regular meeting at Norton on Friday, December 21. The following program had been prepared:

President's address, R. M. Tinney.
Broncho Pneumonia, H. M. Norrish.
Diseases of the Hip Joint, W. C. Lathrop.
Appendicitis, C. W. Ward.
Round table.
Election of officers.

SUMNER COUNTY SOCIETY.

The Sumner County Medical Society met in special session at the Commercial Club rooms, Wellington, Kansas, December 6, 1917, 8 P.M. Officers for the year 1918 were elected as follows:

President, Dr. W. E. Bartlette, Belle Plaine; vice president, Dr. W. M. Martin, Wellington; secretary and treasurer, Dr. J. C. Caldwell, Wellington; censor, Dr. F. S. Netherton, Wellington; delegate, Dr. W. H. Neel, Wellington; alternate delegate, Dr. E. A. Evans, Conway Springs.

After the business hour the society listened to a very interesting lecture on "Internal Secretions" by Dr. W. W. Duke, Kansas City, Mo. There was a good attendance. W. H. NEEL, Secretary.

SALINE COUNTY SOCIETY.

The Saline County Medical Society held its annual meeting in Salina on December 13. Dr. A. L. Skoog of Kansas City was present and gave a lecture on "Brain Tumors," which was very interesting and instructive.

After the regular program the annual election of officers was held and the following were elected for the ensuing year: President, J. K. Harvey, Salina; vice president, C. M. Jenney, Salina; secretary W. E. Mowrey, Salina; treasurer, A. G. Anderson, Salina; delegate, J. A. Simpson, Salina; alternate, E. R. Simpson, Gypsum; censor, O. R. Brittain, Salina.

E. G. PADFIELD, Secretary.

BOOKS.

International Clinics.

Volume IV of the Twenty-Seventh Series. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia, with the collaboration of Charles H. Mayo, M.D. Published by J. B. Lippincott Company, Philadelphia and London. Price, $2.00.

This volume of the International Clinics, like its predecessors, contains many very interesting and instructive papers. Albee has a clinic on military bone surgery that is instructive and timely. One of the papers that a great many physicians will be interested in is on the subject of "Blood Pressure in Pregnancy," by Litzenberg. Tucker presents a study of fifteen cases of brain tumor of obscure localization. These are only a few of the very many subjects of interest that are discussed in this volume.

Diseases of the Skin.

Their Pathology and Treatment.—By Milton B. Hartman, A.M., M.D., LL.D., Professor of Dermatology in the University of Pennsylvania. Seven hundred and sixty-seven pages, with 51 colored plates and 242 cuts in the text. Philadelphia and London: J. B. Lippincott Company. Price, $7.00.

This is an entirely new work and one which promises to be well received. Nothing has been spared in the way of material and workmanship and the author has provided a large number of very excellent illustrations which in treatises on diseases of the skin are of quite as much importance as the text.

The author has attempted to present his subject in harmony with the viewpoint of the general practitioner which is considerable of an undertaking.

The various diseases of the skin are discussed under the following classification heads: Inflammations, Hemorrhages, Hypertrophies, Atrophies, Anomalies of Pigmentation, New Growths, Neuroses, Diseases of the Appendages.

To the subjects of Etiology and Pathology the author has given very thorough attention since in his opinion these are very important to the proper understanding and management of the various lesions. In the treatment he has given the various methods that have been recommended and has been particularly attentive to details in the application of local remedies.

History of Medicine.

Second Edition Revised and Enlarged. Suggestions for study and bibliographic data, by Fielding H. Garrison, A.B., M.D., Principal Assisting Librarian, Surgeon General's Office, Washington, D. C. Octavo of 905 pages with many portraits. W. B. Saunders Company, Philadelphia and London, 1917. Cloth, $6.50 net; half morocco, $8.00 net.

A complete history of medicine, were it possible to uncover and accumulate the manuscript literature of its earlier days, would require several volumes. It is hardly possible to estimate the amount of labor the accomplishment of such a purpose would demand, but a review of this work by Garrison will give some idea of it.

He has given us a very comprehensive view of the progress of medicine and a very interesting compilation of such historical records as are available. In the second edition the work has been improved and enlarged.

A Manual of Anatomy.

By Henry E. Radasch, M.Sc., M.D., Assistant Professor of Histology and Embryology in the Jefferson Medical College, Philadelphia. Octavo of 489 pages with 329 illustrations. Philadelphia and London: W. B. Saunders Company. 1917. Cloth, $3.50 net.

By using much smaller plates and by condensing the descriptive matter somewhat Radasch has been able to put quite a complete work on anatomy into a book of less than 500 pages. Some variation in the arrangement of the text and some change in the nomenclature will be observed.

The Practical Medicine Series.

Under the general editorial charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern Medical School. Price of this series, $10. The Year Book Publishers, 327 So. LaSalle St., Chicago.

Volume IV—Gynecology: Edited by Emilius C. Dudley, A.M., M.D., Instructor in Gynecology, Northwestern University Medical School; Adjunct Gynecologist, Wesley Hospital, Chicago.

Volume V—Pediatrics: Edited by Isaac A. Abt, M.D., Professor of Piadiatrics, Northwestern University Medical School, Attending Physician Michael Reese Hospital; with the collaboration of A. Levinson, M.D., Associate Pediatrician Michael Reese Hospital. Orthopedic Surgery, edited by John Ridlon, A.M., M.D., Professor of Orthopedic Surgery, Northwestern University Medical School; with the collaboration of Charles A. Parker, M.D.

Volume VI—General Medicine: Edited by Frank Billings, A.B., M.D., Head of the Medical Department and Dean of the Faculty of Rush Medical College, Chicago; assisted by Burrell O. Ralston, A.B., M.D., Resident Pathologist, Presbyterian Hospital.

These are volumes of a series of ten issued at about monthly intervals, and covering the entire field of medicine and surgery. Each volume being complete on the subject of which it treats for the year prior to publication.

Price—Volumes IV and V, $1.35; Volume VI, $1.50.

One of the best opportunities of conserving ammonia is made available by the substitution of natural ice for the manufactured product. This substitution is being provided for throughout the country, and it is expected that a very large percentage of the ice used next summer will be ice that the Food Administration is encouraging people to harvest now from rivers and ponds wherever possible.

MISCELLANEOUS

New and Nonofficial Remedies.

Borcherdt's Malt Sugar.—A mixture containing approximately maltose, 87.10 per cent; dextrin, 4.35 per cent; protein, 4.40 per cent; ash, 1.90 per cent, and moisture, 1.95 per cent. It may be used when maltose is indicated in the feeding of infants, particularly in the treatment of constipation. The Borcherdt Malt Extract Co., Chicago. (Jour. A.M.A., Dec. 1, 1917, p. 1875.)

Tyramine-Roche.—A brand of tyramine hydrochloride complying with the standards of New and Nonofficial Remedies. The Hoffman-LaRoche Chemical Works, New York. (Jour. A.M.A., Dec. 1, 1917, p. 1875.)

Atophan. — A proprietary brand of phenylcinchoninic acid complying with the standards of the U.S.P., but melting between 208 and 212 C. For a description of the actions, uses and dosage, see New and Nonofficial Remedies under Phenylcinchoninic Acid and Phenylconchoninic Acid Derivatives. Atophan is sold in the form of pure atophan and as atophan tablets 0.5 Gm. Schering & Glatz, New York. (Jour. A.M.A., Dec. 8, 1917, p. 1971.)

Arsphenamine. — The Federal Trade Commission having adopted the name "arsphenamine" as the term to apply to 3-diamino-4-dihydroxy-1-arsenobenzene, first introduced as salvarsan, the Council on Pharmacy and Chemistry voted to adopt this abbreviated name in place of arsenphenolamine hydrochloride now in New and Nonofficial Remedies.

Arsenobenzol (Dermatological Research Laboratories.)—A brand of arsphenamine. It has essentially the same actions, uses and dosage as salvarsan. It is supplied in ampules containing, respectively, 0.4 Gm. and 0.6 Gm. Manufactured and sold by the Dermatological Research Laboratories, Philadelphia Polyclinic, Philadelphia, Pa.

Salvarsan.—A brand of arsphenamine. Supplied in 0.6 Gm. ampules. Manufactured and sold by Farbwerke-Hoechst Co., New York.

Chloramine-T.—Sodium paratoluenesulphochloramide. It has the actions, uses, dosage and physical and chemical properties given in New and Nonofficial Remedies, 1917, for chlorazene.

Chloramine-T (Calco). — A brand of chloramine-T. Manufactured by the Calco Chemical Co., Bound Brook, N. J.

Novocaine.—The monohydrochloride of paraaminobenzoyldiethylamino-ethanol. Actions, uses and dosage, see New and Nonofficial Remedies, 1917, p. 31. Manufactured by Farbwerke-Hoechst Co., New York. (Jour. A.M.A., Dec. 22, 1917, p. 2115.)

———R———

Patent Medicine Labels Must Speak Truly.

Ten years ago there was no ailment to which human flesh is heir that some maker of patent medicines did not claim to be able to cure with such ease that it seemed almost the height of foolishness not to part with the price for his nostrums.

Today, because of the operation of the Federal Food and Drugs Act, the extravagant promises of cure that characterized the labeling of the patent medicines of ten years ago have practically disappeared from the preparations that enter interstate commerce. They may, however, still be found in newspaper and other advertisements that are not subject to the act. The "pure food law," as it is known, is concerned only with the package as it is shipped in interstate commerce. If one questions the truth of a newspaper advertisement of a patent medicine, let him read the label on the carton or bottle at the corner drug store. The latter will come nearer telling the truth about the medicine.

Misbrandings, in regard to healing value of hundreds of alleged cancer cures, so-called "cures" for coughs, colds, consumption, kidney diseases, epilepsy, St. Vitus dance, and the like, have been corrected. This is told in the annual report of the Bureau of Chemistry, United States Department of Agriculture, which reviews the operation of the Food and Drugs Act

in the safeguarding of the health of the American people.

The law requires the labels of patent medicines to declare the presence of any habit-forming drug, such as opium, cocaine, or alcohol, thus preventing the innocent development of the drug habit. This provision of the law is particularly valuable in warning mothers against the use of so-called infant soothing syrups containing opium.

When the act went into effect, drug addiction was so prevalent that frauds in the treatment of the victims were frequent and in most instances the remedy advertised so forcefully by the labels contained the very drug from which escape was desired.

In 1907 the Bureau of Chemistry found that thirty soft drinks contained small amounts of cocaine. Practically all of these were suppressed. The Food and Drugs Act is regarded as having been an important factor in bringing about passage of the Harrison Anti-Narcotic law, which more effectively controls habit-forming narcotics.

Much has been done, the report says, to control the indiscriminate use of so-called headache remedies containing dangerous, depressing drugs, and of dangerous cosmetics making claim to healing value; and in raising the quality of the supply of crude drugs through the examination of imports. As a result of co-operative work with the Post Office Department, a number of fraud orders were issued by that department preventing the use of the mails in promoting the sale of fraudulent medicines.

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Neutral Sodium Soap.

For some time Dr. Alexis Carrel has been using, in the War Demonstration Hospital of the Rockefeller Institute, for the cleansing of wounds a liquid sodium soap—a neutral sodium oleate. This has been employed with most satisfactory results.

This soap is used to scrub out an infected wound. A little of it is applied to a pledget of cotton, held with a dressing forceps, and the wound scrubbed with it, more soap being applied to the cotton from time to time until there is a good lather. The wound is scrubbed in this way from the center to the periphery, the soap finally being washed away with water, after which the indicated antiseptic is applied, as, for instance, Chlorazene Surgical Cream.

Neutral Sodium Soap, prepared to meet Doctor Carrel's indications, has been placed on the market by the Abbott Laboratories, Chicago, and is now offered to the medical profession.

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The American Review of Tuberculosis is published by the National Association for the Study and Prevention of Tuberculosis, 105 E. Twenty-second St., New York City.

The purpose of the Review is to give the best information available on tuberculosis from both American and foreign sources and on the clinical, pathological and sociological phases of the disease.

It is the only strictly medical journal on tuberculosis published on the American continent. Its editorial staff consists of the following members: Dr. Edward R. Baldwin, Saranac Lake, editor in chief; Dr. Lawrason Brown, Saranac Lake; Dr. H. R. M. Landis, Philadelphia; Dr. Paul Lewis, Philadelphia; Dr. M. J. Rosenau, Boston; Dr. Henry Sewall, Denver; Dr. B. S. Veeder, St. Louis. Dr. Allen K. Krause of Baltimore is managing editor.

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Chloretone: Hypnotic and Sedative.

Chloretone produces natural sleep. It is indicated in many conditions, such as acute mania, puerperal mania, periodical mania, senile dementia, agitated melancholia, motor excitement of general paresis, insomnia due to pain, as in tabes dorsalis, cancer, and trigeminal neuralgia; also insomnia due to mental overstrain or worry.

Chloretone is a valuable sedative in such conditions as alcoholism, cholera and colic; also in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays the nausea of pregnancy, gastric

ulcer and seasickness. In insomnia it is often effective when other drugs have failed.

Chloretone acts upon the central nervous system, but therapeutic doses have little or no effect upon the heart and respiratory center. The hypnotic dose for an adult is from ten to fifteen grains. Good results have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. One large dose the second night rather than two or more smaller doses would seem to be better practice. Its administration is not attended with digestive disturbances.

Ten Years of the Food and Drugs Act.

Ten years of enforcement of the Food and Drugs Act of June 30, 1906, are reviewed in the current annual report of the Bureau of Chemistry, United States Department of Agriculture, which says that the Act's chief contributions to the safety of the people's health have been its corrective effect upon the drug and patent medicine industry, its control of trade in unclean milk, polluted, decomposed or filthy foods, and protection of foodstuffs from contamination with poisons likely to be met in manufacture.

The general effect of the Food and Drugs Act may best be estimated, says the report, by considering its effect upon food and drug control by the states; upon development of the food and drug industries and by the principal abuses that have been corrected. But to illustrate the scope of the work through figures and facts the report points out that more than 6,000 prosecutions have been terminated in the courts in the first decade of the Act; that manufacturers have been cited at hearings more than 40,000 times, that many thousands of factory inspections have been made, and that more than 750,000 shipments of domestic or imported food and drugs have been examined.

Special attention has been given to shipments of polluted or spoiled food. Milk shipped in interstate commerce and imported from Canada has been improved in cleanliness, purity, and the condition of sanitation under which produced. The canning of decomposed navy beans has been largely suppressed. Interstate shipment of oysters from polluted waters has practically ceased. Because of co-operation with state and municipal officials in controlling the shipment of bad eggs, it is reported that the quality of the eggs reaching the large cities is much improved. Other products in whose handling and sale improvement has been noted include mineral water, tomato products, fruit, vinegar and gelatin.

One consequence of the enactment of the Food and Drugs Act was to encourage similar legislation in many of the states the purpose of which is to control local traffic in food and drugs which, since no interstate commerce is involved, are not subject to the federal law. For example, in 1906 many states had no feeding stuffs laws. A state could not prosecute a manufacturer unless he were a citizen of that state. The federal law supplements the state law in this respect and now most of the states have similar laws.

In the beginning the confusion and apparent conflict between local and federal laws and administration of laws not only made it difficult for the two sets of officials to co-operate, but often made it necessary for manufacturers to make special preparations for shipment to certain states at extra cost, the extra cost being passed on to the ultimate consumer. This evil has been remedied to a considerable extent by the organization of two agencies which in a large measure have removed some of the difficulties arising from the conflict of federal and state jurisdiction. These agencies are (1) the Joint Committee on Definitions and Standards and (2) the Office of Co-operative State and Federal Food and Drug Control.

Deaths of Physicians in 1917.

During 1917, the deaths of 2,300 physicians in the United States and Canada were noted in the Journal of the American

Medical Association. On an estimate of 160,000 physicians, this is equivalent to an annual death rate of 14.37 per thousand. For the fifteen previous years the mortality rates were: 1916, 14.08; 1915, 15.71; 1914, 14.41; 1913, 14.64; 1912, 14.13; 1911, 15.32; 1910, 16.96; 1909, 16.26; 1908, 17.39; 1907, 16.01; 1906, 17.20; 1905, 16.36; 1904, 17.14; 1903, 13.73, and 1902, 14.74. The average annual mortality for the period from 1902 to 1917, inclusive, was, therefore, 15.53 per thousand.

Ages.—Of the decedents, 55 were between the ages of 21 and 30; 178 between the ages of 31 and 40; 367 between 41 and 50; 449 between 51 and 60; 503 between 61 and 70; 431 between 71 and 80; 170 between 81 and 90, and 27 between 91 and 100. The greatest mortality occurred at the age of 61, when 63 deaths were recorded.

Causes of Death. — There were 191 deaths assigned to general diseases; 246 to diseases of the nervous system; 296 to diseases of the circulatory system; 208 to diseases of the respiratory system; 86 to diseases of the digestive system; 115 to diseases of the genito-urinary system; 388 to senility; 31 to suicide; 111 to accident; 23 to homicide, and 66 after surgical operation. Among the principal assigned causes of death are senility, 388; heart diseases, 202; cerebral hemorrhage, 195; pneumonia, 189; accident, 111; nephritis, 86; surgical operation, 66; tuberculosis, 44; malignant disease, 40; suicide, 31; arteriosclerosis. 30; angina pectoris, 29; septicema and homicide, each, 23; diabetes, 22; uremia, 17; gastritis, myocarditis and appendicitis, each 16; intestinal disease (unclassified) and influenza, each 14; anemia and typhoid fever, each 13; meningitis and brain disease (unclassified), each 11; influenza, nervous disease (unclassified) and kidney disease (unclassified), each 10; erysipelas, 8; endocarditis, choleiithiasis and peritonitis, each 7; embolism, asthma and respiratory diseases (unclassified), each 6; neuritis, gastric ulcer and liver disease (unclassified), each 5; rheumatism, leukemia, bronchitis, cirrhosis of the liver and dilatation of the heart, each 4; dysentery and spinal disease (unclassified), each 3; malaria, diphtheria, paresis, general paralysis of the insane, pleurisy, hernia, intestinal obstruction, duodenal ulcer, prostatitis and dropsy, each 2, and 1 death from anthrax, pellagra, chronic articular rheumatism, insanity (unclassified), paralysis agitans, anterior poliomyelitis, ear disease (unclassified), mastoiditis, aneurysm, lymphatic disease (unclassified), pulmonary emphysema, and purpura hemorrhagica. One physician died in prison, and seven medical officers lost their lives in battle.

The causes assigned for the 111 deaths from accidents were: automobile, 41; falls, 11; railway-automobile (grade crossing). 9; railway, 9; drowning, 10; firearms, 8; poison, 4; burns, 6; sunstroke, 4; freezing, 1; lightning, 1; explosion, 1; electricity, 1; machinery, 1; horses and vehicles, 1; other accidental traumatisms, 3, and suffocation, 1. The 31 physicians who ended their lives by suicide selected the following methods: firearms, 15; poison, 5; hanging, 2; cutting instruments, 3; drowning, 1; jumping from high places, 1, and other means, 4. Of the 16 homicides, 11 were due to firearms; 2 to cutting instruments, and in 3 the method was not reported.

The chief death causes in the order named were senility, heart disease, cerebral hemorrhage, pneumonia, accident, nephritis and surgical operations. The age at death varied from 21 to 100, with an average of 60 years, 8 months, 13 days. The general average of age at death since 1902 is 59 years, 9 months and 2 days. The number of years of practice varied from 1 to 70 years, the average being 32 years, 7 months and 1 day. The average for the past thirteen years is 31 years, 2 months and 11 days.

Military Service.—During the year, 215 peysicians died who had served in the Civil War; of these, 59 had followed the fortunes of the Confederacy, and 61 had been medical officers of the United States Volunteers. The Medical Corps of the Army lost 10 officers; the Medical Reserve Corps, 20; 15 had been contract or acting

assistant surgeons, and 2 were medical cadets. The Navy lost 14 medical officers: the Public Health Service, 7; the Indian Service, 3, and the organized militia, 31, of whom 5 had attained the grade of Surgeon-General.

Civil Positions.—Of those who died, one had been a member of Congress; one, the governor of a state; one, an ambassador; 11, members of state senates; 34, members of the lower houses of legislatures; 38 had been mayors.

Association Fellowship.—Of the 689 Fellows of the American Medical Association who died during 1917, two had been vice presidents; one, a member of the House of Delegates; two, members of the Committee on National Legislation; one, a member of the Council on Pharmacy and Chemistry, and one, a member of the Board of Trustees.—Journal A. M. A., Jan. 5, 1918.

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Blood Pressure in Obstetrics.

J. L. Slemons, New Haven, Conn. (Jour. A. M. A., Sept. 8, 1917), summarizes his observations of the value of blood pressure observations in pregnant women substantially as follows: Blood pressure observations afford the means for the early detection of pre-eclamptic toxemia and the severity of the auto-intoxication, and also are useful occasionally in the differentiation of pyelitis from the albuminuria of pregnancy. They also give a measure of the efficiency of treatment of active eclampsia and a method of obtaining the ultimate prognosis in these cases. When patients are carrying a double burden of chronic valvular heart trouble and toxemia, knowledge of the blood pressure is indispensable as a therapeutic guide. Since knowledge is also required from estimating the work the heart is doing, by this means we shall probably obtain a more timely method of recognizing the approach of a breach in compensation in chronic valvular heart disease, and therefore be able to decide the question of the induction of labor as a prophylactic. He has tried the use of lumbar puncture in five cases of eclampsia, as reported on by Wilson, and considers that while it may not be implicitly relied on to check or modify the convulsions, it adds another therapeutic measure to our arsenal. In two desperate cases immediate improvement followed the measure.

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Insolubility of Gelatin Capsules.

F. W. Dershimer, British Guiana (Jour. A. M. A., Nov. 3, 1917), remarking on the task of making drugs palatable thinks we may overdo the matter. Experiments seem to prove that soft gelatin capsules may protect the drugs from the action not only of the saliva but from the gastric and enteric juices. He has experimented with both hard and soft capsules in a pepsin solution slightly acidified with hydrochloric acid. The hard capsule completely dissolved in about twenty-one minutes, but the soft capsule showed no signs of dissolving after twenty-four hours. Recently the writer's attention was again called to the matter by a memorandum from Walaya Health Board which reported that the soft gelatin capsules were not easily soluble and showed a decrease in their efficiency in the treatment of hookworm. He then repeated his experiments, which gave similar results and seemed to indicate that drugs should not be administered in soft gelatin capsules with any hope that they will act efficiently.

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Intubation of the Larynx

H. J. Cartin, Johnston, Pa. (Journal A. M. A., Aug. 11, 1917), gives an analysis of 350 cases of laryngeal intubation occurring in his private practice in a region largely inhabited by foreigners living under unsanitary conditions and inclined to conceal disease through fear of quarantine, and where naturally epidemics of diphtheria are common. The analysis is rather elaborate, but his conclusions from it are given as follows: "1. No patient needing intubation should be denied the chance to live because of lack of hospital facilities. 2. Overcrowding of homes, unhygienic surroundings, concealment of disease, and exposure to contagion are re-

sponsible for the epidemics. 3. Lack of trained assistants need not deter one from operating. 4. The use of a tube larger than that indicated for a given age gives better results. 5. Early intubation with large doses of antitoxin reduces the mortality. 6. Wearing the tube five days resulted in fewer reintubations. 7. It appears that special diet and methods of feeding are unnecessary. 8. Reintubation does not seem to affect phonation permanently."

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Pericardium

A comparison of the compression and Roentgen-ray findings after injection of the pericardium, made after experimental work with fresh human cadavers, is reported by R. S. Morris and Ellis R. Bader, Cincinnati (Journal A. M. A., Aug. 11, 1917). Experiments and methods are described with special reference largely to the question of presence or absence of an obtuse cardiohepatic angle. The findings are summed up in the following: "Our findings in fresh cadavers show that retrosternal dullness, with increasing retrosternal shadow in roentgenograms, is a relatively early phenomenon after injection of the pericardium with serous fluid, and suggest that shifting retrosternal dullness (loss or marked decrease in dullness, with decrease in the shadow of the fluoroscope or in plate) may be a relatively early sign of pericardial effusion. With fluid under great pressure in the pericardium on the other hand, marked shifting dullness will probably largely disappear." The article is illustrated.

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Diabetes.

A. C. Crofton, Chicago (Journal A.M.A., December 8, 1917), believes that in mild cases of diabetes and in those of medium severity, the rigorous starvation plan of treatment is ineffective and, in some cases, more dangerous than the old methods. As to tolerance, in the milder cases he has never seen an increase in tolerance for carbohydrates, finding it, on the contrary, usually reduced. The excretion of acetone bodies to an alarming degree is liable to take place in this type during starvation or after the resumption of carbohydrate feeding, though in the hospital this, as a rule, can be regulated. As an emergency measure, the method is useful. Starvation, however, is usually employed by the general practitioner who, being outside an institution, has not the facilities to learn the technic of controlling these cases, thinks it is easy to foresee possibilities of danger. Edema, when occurring in diabetes, he considers a symptom due possibly to the starvation treatment. It is a danger signal of coma and is due to retention of water when the starvation treatment is used. When it occurs, it is a sign to resume feeding. The use of sodium bicarbonate in large doses leaves the patient, as far as his tolerance is concerned, in a worse condition than before the starvation plan was inaugurated.

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Recurrent Laryngeal Nerve Paralysis.

G. E. Brown and B. E. Hempstead, Miles City, Mont. (Journal A.M.A., January 5, 1918), report a case of recurrent laryngeal nerve paralysis associated with mitral stenosis. The usual association of this paralysis is with aneurysm and aortic arch dilatation, and it is only since Ortner's original report in 1897 that we have learned that recurrent paralysis may be associated with and apparently caused by cardiac enlargement. In a series of 360 cases studied by Thompson, in St. Clair, only ten were reported as being due to an enlargement of the heart in mitral stenosis. Up to 1916 only eleven cases had been reported with necropsy confirmation, but a number of clinically reported cases with a recurrent paralysis have been reported in which the cardiac condition could be proved the causative agent. The proof has become more exact since the advent and general use of the roentgen ray in chest diagnosis. It was used in the writers' patient, and they comment on it as follows: "This was a case of mitral stenosis, associated with temporary paralysis of the left re-

current nerve during a period of mild decompensation, in which, under appropriate treatment, the left auricle increased in size. This reduction in the size of the auricular chamber evidently released a pressure on the left recurrent nerve with restoration of its function. The case is the only one of this particular type that we have been able to find in which a diagnosis could be made early enough to allow the nerve function to return. The case illustrates the importance of a rigid investigation of every case of left laryngeal paralysis to rule out its more common causes, as no other etiology offers a better chance of relief than this particular type."

Pneumococcus Carriers.

Recent studies on the epidemiology of lobar pneumonia show that it arises by infection from without, the pneumococci being transferred from other individuals. In studies of a large number of healthy persons who have been in contact with pneumonia due to Type I or II pneumococci, it has been found that about 12 per cent were carrying pneumococci of the corresponding types. J. A. Kolmer and Edward Steinfield, Philadelphia (Journal A. M. A., January 5, 1918), review the literature of pneumonia carriers, declaring that it would seem advisable to attempt the destruction of pneumococci in the mouth secretions of convalescents and healthy persons who have been in contact with patients. Wadsworth has already tested the disinfecting power of saline solutions and bland alcoholic washes. European and American investigators have shown the high pneumococcidal activity of ethylhydrocuprein hydrochlorid as found by Kolmer and Heist. Other cinchonics, such as quinin and urea hydrochlorid and quinin bisulphate, also possess considerable pneumococcidal powers. The writers, therefore, in this article report their experiments on this disinfection of sputum and the mouth by these various cinchonics in a menstruum of liquor antisepticus.

[Continued on page xv]

FOR DIAGNOSTIC AID

Smears
Sputum
Urine
Blood
Feces
Stomach Content

$1.00 TO $5.00

Wassermann Test
Gonorrheal Complement Fixation
Lange's Colloidal Gold Test
Autogenous Vaccines
Tissue Diagnosis
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Their experiments demonstrate that the latter solution alone, in dilution from the proportion of 1 to 4 to the propertion of 1 to 10, possesses some germicidal activity for pneumococci, and also aids in disguising the bitter taste of cinchona compounds. The results of their experiments with the sputum have indicated that dilution of ethylhydrocuprein hydrochlorid as high as 1 to 30,000, and even to 1 to 160,000, had appreciable and frequently well-defined effects, while a 1 to 10,000 dilution almost invariably disinfected sputum containing pneumococci. The other conchonics in solution varying from the proportion of 1 to 10,000 to the proportion of 1 to 20,000 were also found to possess definite disinfectant qualities. Many trials have convinced the writers as to the disinfecting value of the substances mentioned. Since the fact has been established that a considerable percentage of convalescents and persons who come in contact with lobar pneumonia become carriers, the writers would advise the clinical trial of these disinfectants in the patients themselves, and on patients suffering from measles or other diseases favoring the development of lobar pneumonia. The systematic use of 1 to 10,000 solution of ethylhydrocuprein hydrochlorid in a 1 to 10 dilution of liquor antiseptic us twice or more daily is not dangerous from the standpoint of toxicity due to swallowing portions of the drug. Nor is it unpleasant, and it may aid in ridding the mouth of virulent pneumococci. Since this drug is scarce at present, the other cinchonics may be substituted, though these are less powerful pneumococcides. Similar dilutions of undiluted Dobell's solution may be used for douching or spraying the nose or may be incorporated in a dental cream for use on the teeth.

———℞———

Emetin in Cancer.

There are some observers, especially among clinicians, says Richard Lewisohn, New York (Journal A. M. A., January 5, 1918), who hold the belief that the etiologic factor in malignant neoplasms is

[Continued on page xvii]

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amebic. The possibility of this suggested to him the trial of the alkaloid emetin in cases of human cancer. The present paper is due to the report by Dr. Mary Freeman that she had used emetin locally with seeming success in cancer. The writer reports two operations for cancer, in which local injections of emetin were tried. The local symptoms were promising at first, but one of the patients died from an internal metastasis. The other seems to be in perfect health, but the roentgen ray shows a shadow in the lung. Animal experiments were made on rats and mice. The injected cancers showed necrosis and scab formation, and in the majority of cases the scab fell off after a week, leaving an indurated area. Microscopic examinations showed practically a total absence of tumor cells, evidently due to the cell-destroying action of the emetin. In other experiments it was shown that the injections of the fluid into the tumor had no effect in producing the results. His conclusions are given as follows: "1. Injection of emetin into carcinoma and sarcoma may cause a complete macroscopic disappearance of most of the tumors. This disappearance is not due to a specific action of emetin on the tumor cells. The action of the drug is purely caustic, similar though in less degree to the action of phenol (carbolic acid), zinc chlorid, etc. 2. Repeated intravenous injections of emetin do not effect the growth of carcinomas and sarcomas. This proves conclusively that emetin has no specific effect on the growth of malignant tumors. 3. These observations do not strengthen the amebic theory of malignant tumors."

Neodiarsenol.

E. P. Zeisler, Chicago (Journal A.M.A., December 29, 1917), discusses a recent series of twenty intravenous injections of neodiarsenol, a recent substitute for neosalvarsan marketed by a Canadian firm, which he gave to patients in all stages of syphilis. He observed an unusually large percentage of severe reactions, such as fever, headache, vertigo, vomiting, nausea,

[Continued on page xviii]

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faintness, thoracic oppression sometimes extremely alarming, at least it was in one case. On account of his unpleasant experiences in the use of neodiarsenol, he has ceased to use it and has since employed the French preparation, novarsenobenzol (Billon), which has given satisfaction.

———R———

Vital Capacity and Heart Disease.

C. W. McClure and F. W. Peabody, Boston (Journal A.M.A., December 8, 1917), call attention to the importance of a decrease in vital capacity of the lungs as a factor in the production of dyspnea in heart disease. The degree of decrease of vital capacity below certain normal standards corresponds closely to the tendency to dyspnea. Since this tendency depends largely on the functional capacity of the heart, the determination of the vital capacity of the lungs may serve as an indirect index to the cardiac condition. This has been determined by the authors in a series of twenty-four cases, as shown by the tables which the writers present. Improvement in the functional state of the heart is associated with a rise in the vital capacity. When the heart condition is apparently stationary, changes in the pulmonary vital capacity are not marked and when there is evidence of increasing cardiac insufficiency the vital capacity of the lungs also fails. Charts showing the variations in the vital capacity of the lungs of patients with heart disease are frequently satisfactory objective records of the clinical course of the disease and may be an aid in prognosis.

———R———

Doctor—"Have you been the victim of an assault?"

Patient—"Oh, no, sir. I simply fainted and was brought to by a Red Cross Nurse's Voluntary Aid."

———R———

Help the Doctor.

First Voluntary Aid—"This patient's temperature is 105 degrees. That's awfully high, isn't it? What shall I do?"

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, FEBRUARY, 1918 No. 2

Freudian Psychology.

MAUD S. DELAND, M.D., State Hospital.

Read before the Shawnee County Medical Society.

This paper is merely an effort to show that the Freudian theory is not something unique, bizarre or different from the science of biology, but on the contrary it is quite in keeping with modern physiology in considering man as an adaptive mechanism. Nothing original is claimed; in fact, the chief claim this paper has to your consideration is that it is merely a compilation from books and technical magazines written by people whose extensive work and experiments entitle them to a hearing. Except where condensation was necessary, the exact wording of the author has been preserved in order that the meaning may not be distorted.

For years past we have been observing the symptoms of mental disease and perfecting a classification based thereon. This is good as far as it goes. It is good to know typhoid fever, diphtheria and malaria as clinical entities and to know how to treat them to get the best results, even though that treatment be purely empirical. But it is far better, both from a practical and scientific standpoint, to know their etiology. And so it is with mental diseases. We wish to know the specific causes operate. How far we are from this causes producing them, and just how these ideal state of affairs may be shown by the various theories put forth by their enthusiastic advocates. True, we know that brain changes resulting from syphilis may give us dementia paralytica, simple syphilitic dementia, pseudo-paresis, or a tabetic psychosis; and that brain tumor and abscess and apoplexy and cerebral trauma give us their characteristic symptoms and signs, that alcohol and certain drugs give us the intoxication psychoses, and that hardened arteries and senility induce mental changes corresponding with the physical brain changes. But there still remain the neuroses and the psychoses which present no characteristic brain changes to account for the mental changes in such diseases as manic-depressive insanity, paranoia, neurasthenia, hysteria, anxiety and obsessional neuroses, and perhaps the early stages of dementia præcox.

Are these diseases somatogenic or psychogenic?

Some advance a theory of a disordered secretion of the ductless glands, others a disturbance of metabolism, or some other vague terms as mental or physical strain, and one paper even goes so far as to connect mental disease with a disturbance of kidney function!

On the other hand there has grown up a school of investigators who are conceiving life as a dynamic force and are approaching the problem from the psychic side; pre-eminent in this class is Sigmund Freud. Some of Freud's followers think of him as a second Darwin, claiming that he has done for the mental life what Darwin did for the physical; others are bitter in their denunciation of him, which argues nothing against his theories but merely shows that he has come in conflict with the traditions of the race or touched a complex of the individual.

But before looking at Freud's theories, let us get rid of the idea of the dual nature of man and consider him as a biological unit. Let us also note that some of our greatest scientists consider an idea not as something spiritual and apart from the physical, but as a dynamic force which reacts on the physical.

Sherrington traces the integration of the nervous system from the simple reflex arc to the complex co-ordinations of the brain and concludes that the cerebral cortex is the organ of and for the adaptation of nervous reactions.

"The child is born into the world with no mind, no consciousness, but with a central nervous system and special sense organs." From the moment of its birth it begins to receive sensations from the outer world and react to them, and the manner of its reaction is the result of the adaptation of its progenitors, through natural selection, throughout the eons required to evolve the species. As William A. White, of the Government Hospital for the Insane at Washington, so clearly puts it,

"In no other way can the stuff out of which the mind is made find its way to the brain except by the sensorium. Whatever man may become must, in the last analysis, depend upon this material, and so no conception of mind can fail to take it into account. A person at any particular moment is the end result of all the processes that have been at work since his conception and in the same way a given state of mind can only be conceived to be what it is because of all that has gone before—it is the end product."

Loeb, in his "Mechanistic Conception of Life," has shown how certain insects must go to the light even though it means their destruction because of their light tropism. After numerous experiments with physical and chemical changes in animals he says:

"I believe that the investigation of the conditions which produce tropisms may be of importance for psychiatry. If by means of an acid we can call forth in an animal otherwise indifferent to light a heliotropism which drives it irresistibly to a flame; if the same thing can be brought about by means of a secretion of the reproductive glands, we have given, I believe, a group of facts, within which the analogies necessary for psychiatry can be called forth experimentally and can be investigated.

"These experiments may also attain a similar value for ethics, namely, the condition that human beings are willing to sacrifice their lives for an idea is comprehensible neither from the utilitarian standpoint nor from that of the categorical imperative. It might be possible that under the influence of certain ideas chemical changes, for instance, internal secretions within the body, are produced which increase the sensitiveness to certain stimuli to such an unusual degree that such people become slaves to certain stimuli, just as the copepods become slaves to the light when carbon dioxide is added to the water."

Since Powlow demonstrated in his experiments on dogs that gastric juice could be caused to flow by means of optic and acoustic signals which had formerly been associated with feeding, it no longer seems strange to us that what the philosopher terms an idea is a process which can cause chemical changes in the body. This response to an associated stimulus is called a conditional reflex and is made use of by all animal trainers.

Cannon, professor of physiology at Harvard, shows us the effect of the emotions on digestion, also on adrenal secretion and the liberation of blood sugar, and how these latter in turn raise the blood pressure and also increase muscular contraction, counteract fatigue, and hasten the coagulation of the blood. He shows us the utility of the emotions in great crises, in competitive sports, and in battles. He also calls attention to the fact that emotions must have an outlet, and that nervous strain and restlessness due to a baulked disposition may result from the absence of circumstances which would call the emotional responses into action.

It has remained for Crile to give us the most complete picture of man as an adap-

tive mechanism. By extensive experiments he has found that fear, traumatic injury and the exertion of running or fighting produce the same histological changes in the brain, the adrenals and the liver. It is obvious, therefore, that these three types of exhaustion are similar, the difference being that fatigue from physical exertion results from the integration of the motor mechanism with complete response in activity or obvious work performed; while shock or exhaustion caused by emotion results from an integration of the nervous mechanism without obvious work performed. In the latter case the exhaustion is comparable to the effects produced in an electric automobile which has been integrated to go ahead by a closed circuit, while the wheels of the machine are held immobile.

According to Crile, "The brain is the initiator of response, being activated by the environment within or without the body; acting like a storage battery, it contributes the initial spark and impulse which drives the mechanism.

"The adrenals act as oxidizers, making possible the transformation of energy and the neutralization of the resulting acid products.

"The liver is the chief fabricator and storehouse of the carbohydrate fuel by which muscular action and heat are produced. The liver also plays a large role in the neutralization of the acid products of the transformation of energy.

"The muscles are the engine or motor in which is consummated the final step in the transformation of energy into heat or motion.

"The thyroid by supplying a secretion which facilitates the passage of ions would seem to be the organ of speed control governing the rate at which the transformation of energy is effected."

And these organs which bear the brunt of the transformation of potential into kinetic energy and the neutralization of the consequent acid by-products and have been evolved for that purpose are termed by Crile "the kinetic system."

Summing up Crile's mechanistic conception of the universe with man as an adaptive mechanism we may say that the child comes into the world with a definite inheritance due to mechanistic conditions. He may be a normal healthy child or he may be stunted from the mother's lack of certain salts or of iodine, or the poisons of syphilis or excessive emotion. Whatever his inheritance, he struggles to adapt himself to his environment in infancy, in childhood, and during adolescence. He transforms energy at the incidence of adequate stimulus in accordance with phylogenetic and ontogenetic association or memory into acts. His kinetic system is driven by injury, by emotion, and by infection, and many diseases result from his struggle with his external and internal environment.

The history of the race has been the history of adaptation to environment from life in the trees to the use of tools and fire and shelter and means of communication. As man became more and more completely adapted to his environment, his numbers increased until in his desire to possess the earth he found his most formidable enemies to be his fellow men; hence, we see this human animal prone to kill because his evolution has depended upon his ability to conquer brute animals and his fellow man. We see that his two most complete adaptations are those of killing and procreating — the inevitable sequel of the primal needs of self preservation and for the preservation of his species.

"The most powerful activator of the kinetic system of man today is his fellow man. This is the enemy he most fears. In the midst of plenty he strives for more. He is at war with his fellows in business, in education, in the arts, in the professions, in philanthropy, and in winning mates. There is no game nor sport that is not a battle. Even the toddling child, when pursued, turns at bay when captured; an obvious recall of the bloody abyss of phylogeny, since all animals turn for the final death struggle. In all his waking moments and even in his dreams,

man exerts himself against his fellows. He fears; he hopes; he triumphs; he is vanquished; he is jealous and suspicious. Yet with all his fears and struggles, he is forever bound to his fellows by the chains of necessity, for he cannot succeed alone. Man is of necessity a gregarious animal. He hates and fears, while at the same time he is grateful and dependent. The rivalry and jealousy of his life turn to grief at the death of his rival. And in these emotions and strivings are laid the foundations of many diseases. These antithetic relations between individuals are exhibited on a vast scale by nations in mutual dependence, mutual help, mutual jealousy, mutual hate and mutual efforts to kill. The effect of fear, grief, worry and jealousy on the physical body is seen in the changes in the cells of the brain, the adrenals and the liver in the numerous resultant diseases and disabilities. Against man's inhumanity to man, religions and philosophies have been evolved, each of which aids in proportion to its power to substitute faith for fear, to substitute altruism for selfishness."

"Excessive anger, work, jealousy, envy, worry or grief cause physical damage as serious as that produced by infections or crushing blows."

Now turning from Crile the scientist and surgeon, to Freud, the scientist and psychologist, and remembering that the most powerful activator of the kinetic system of man today is his fellow man, and that fear, worry and hate affect the physical system, let us briefly consider the theories of Sigmund Freud.

Previous to Freud, Mesmer, Braid, Janet, Sidis, Prince and White had worked on the problems of dissociation, hypnosis and hysteria, but Freud was the first to formulate an hypothesis which considered that each psychic event had a history, and which has led to the same recognition of the value of the past of the psyche as has been for so long accorded to the past of the body in the sciences of embryology and comparative anatomy. "This past does not have only a temporal significance, but as in the sciences of embryology and comparative anatomy, a much greater significance expressed in terms of developmental progress. To understand, therefore, the meaning of a given psychic event, means that the problem of its meaning must, quite as in the case of the body, be approached from the genetic point of view."

The central feature of the Freudian system is the conception of mental conflict. From an early period of life the child finds the gratification of its instinctive impulses checked or even prevented by the pressure of its environment. Conflict is thus set up between the two forces of instinctive pressure within and social pressure without. Instinctive forces which thus come into conflict with the repressing or social force are not destroyed but are deflected from their natural outlet, are repressed within the mind and ultimately prevented from rising into the conscious field at all except in disguised or symbolic forms. To the adult his childhood seems to have been altogether free from any kind of sexual activity or interest, not because. as is generally supposed, such has never existed, but because it has proved incapable of persisting in the conscious field and was suppressed into the unconscious with the increase of social repressing forces.

Similar impulses experienced in adult life which are for the same reason incompatible with conscious recognition do not become conscious, but live their lives in the unconscious, though they may exercise the profoundest influence on the happiness and health of the subject.

Right here it may not be amiss to note that in this conflict between the instinctive impulses of self-preservation and sex on the one hand and the social repressing force on the other, Freud has concentrated his attention on the former, though fully recognizing the potency of the latter, and it has remained for Trotter, of London, to show us that any force which can take the immensely powerfust instinct of sex and mould and deform its prodigous mental energy must in itself be a powerful instinct, and he calls it the herd instinct,

for man is a gregarious and not a solitary animal, and he possesses a specific sensitiveness to environmental influences.

True conflict which moulds and deforms must be actually within the mind—must be endo-psychic, to use a term invented by Freud.

In order that a desire may set up conflict, it must be thwarted, not by a plain impossibility or by mere physical pain, but by another impulse within the mind antagonizing it. For instance, a child may have certain desires which he cannot gratify because of a physical impossibility. This establishes no conflict because the resistance is wholly external, and the whole child still desires its pleasure and its whole resources, mental and physical, are directed to gain the object. Or in another instance the gratification may prove physically painful in itself, as when the child burns its fingers in securing a desired object. But the source of this pain is external and the only emotional quality is that of its unpleasantness, and this cannot enter into the child's mind and divide it against itself.

Thus we see that the essence of mental conflict is the antagonism of two impulses both of which have instinct behind them. Thus only can the mind become a house divided against itself.

Freud lays little stress on any conflict due to repression of the instinct of self-preservation, but that is because society allows a normal expression of that instinct and any repressions necessary are explained to and understood by the child, whereas the repression of the sex instinct is manifested, as Trotter says, "not merely in direct precepts, in warning, in punishment, in expressions of disapproval or disgust, but in a whole system of secrecy, of significant silences, of suppressions, of nods and winks and surreptitious signallings, of sudden senseless snubs and patently lame explanations amid which such sexual interest as the child possesses has to find a modus vivendi and an intelligible meaning."

This brings us face to face with the question of why the sex instinct is suppressed, and we turn not to ethics but to biology for our answer. The powerful sex instinct in its primitive form produced eggs and sperm. In the process of development, a part of this instinct was diverted from its original destination and a definite quantity was used up in the mechanisms of mutual attraction and protection of offspring. Still later in the process of evolution primitive races dimly discerning that certain things were not good for the tribe, established taboos. These taboos form the basis of many customs and may become incorporated in a religion. So society, faintly conscious that a small amount of the sex instinct served for the preservation of the species, established a taboo on its exercise except under certain conditions and limitations, and thus the rest of this energy is diverted from its original aim and becomes a creative force for the good of society. It is to this sublimation of the sex instinct that we owe all our art, our music, our poetry, our religion. Small wonder is it then that Nature, caring only for the progress of the race and indifferent to the welfare of the individual, demands of the individual that he curtail the gratification of his instincts and devote the energy thus saved to the upbuilding of this complex creation we call civilization.

This repressed sexual instinct betrays itself by a feeling of impropriety or disgust when the subject of sex is made a matter of discussion and affords an excellent example of a defence mechanism. If there were no repression, the discussion of a sexual subject would be of no more interest nor arouse any more emotional reaction than the subject of digestion.

Now a word in regard to what is meant by the unconscious. The unconscious in the Freudian sense does not mean something that is merely out of the focus of attention for the time being and is capable of voluntary recall. It means something which one does not really know, but is compelled in the analysis by conclusive inferences to recognize. No better exam-

ple of this can be obtained than what occurred in this hospital some years ago when the campaign for woman's suffrage was on. I was an enthusiastic advocate of suffrage and the men of the staff were just as ardently opposed—or said they were. At the same time, two of our staff were interested in hypnotism, and Doctor No. 1 hypnotized Doctor No. 2 and told him that at 11 o'clock the next morning he was to go into the front office, take a book from the bookcase and lay it on my desk. At 11 o'clock Doctor No. 2 appeared in the front office, walked about the room, stopped in front of the bookcase, selected a book on mental diseases, threw it on my desk and said, "There, if you would devote more of your time to studying that book and less to talking suffrage, it would be better for you." Of course we gave him the laugh and gave him the explanation of his actions, but even then he had absolutely no memory of what had occurred during the time he was hypnotized. Now if the commands of the hypnotizer can drive anything completely from the consciousness of the individual, does it seem very hard to believe that when the whole force of the psyche is exerted to repress a wish or emotion it can be driven into the unconscious beyond all power of the individual to recall?

This experiment illustrates another thing, and that is that we are actuated by motives of which we are unconscious. Doctor No. 2 was impelled by a force he knew nothing about to lay that book on my desk, but he explained the impulse as a philanthropic desire to advise me for my own good, and he fully believed in his own explanation. This is called the process of rationalization. We are actuated by motives of which we are unconscious, but our explanations are in accordance with our ideas of what is right and proper. This lets us do what we want to do, but by assigning the proper motive permits us to retain our good opinion of ourselves. A good example of this is seen in the so-called good men and women who enjoy a scandal. They fear to do anything improper, yet they gratify their erotic and vicious desires by repeating the delicious morsel of scandal while at the same time preserve an exalted idea of their own goodness by professing a horror of what has been done. Were the bad things really abhorrent to their unconscious selves, they would neither read nor repeat them.

Another term in frequent use in Freudian literature is the complex. A thought complex is a system of ideas or associations with an especially strong emotional tone. For instance, a young man in love will be more acutely attuned to anything touching on the subject of love or domesticity than one who is not. Also, a person who is much interested in politics and has been strongly identified with a political party will find it hard to look at any proposed measure absolutely on its merits. We used to say he had a party bias, now we say he has a political complex.

Personality may be defined as a collection of unified complexes existing together and constituting the individual mind. In order to eliminate conflict, an idea incompatible with our beliefs or training may be rationalized, which as we have seen is often a species of sophistry which allows us to continue a course of action out of harmony with our ideals, or the conflicting complex may be repressed. Now if this complex is successfully repressed and its energy sublimated, we have no symptoms, no neurosis. But often the instinctive desires are too strong for our social conscience, and the repression is only partially successful. When a thought complex is repressed because of its incompatibility with the better part of the personality, and its intellectual content is forgotten by the active working mind, its emotional tone remains in the under mind unsynthetized with the personality as a disassociated or segregated bit of mind. Because of its intellectual content (for instance the desire for another's wife) is not acceptable it is turned down and not known to exist, but none the less it is active and *something must become of its energy.*

Freud points out that here is to be found

the cause of the mental and physical symptoms which we are called upon to treat in the psychoneuroses. The headaches, confusional states, faints, epileptiform seizures, tics, obsessions, phobias, impulsions, spasms, and paralyses are all dependent upon the displacement of this conflicting disassociated energy into neutral paths that happen to be open and hence offer the least resistance to the spurious energy which has failed to find its outlet through normal synthesis with the rest of the conscious personality and hence has become diverted into some of these less resistant channels and converted into symptoms.

Let us take an example. "Suppose our patient to be an esthetic young man of high ideals. At a watering place one summer he meets a charming young woman whom he learns to love. He has about made up his mind to propose when he is unexpectedly introduced to her husband (psychic trauma). All the associations and desires which go to make up his love complex have suddenly become incompatible with his ideal of manliness and must be forgotten (repression) if he is to live at peace with himself. At the time of introduction he had walked to the depot in the sun after a large meal, and so had some palpitation and a slight headache, the engine was making a distracting noise (accidental moment). He succeeds in forgetting to thing of the young woman in the light of a lover but he gradually develops a chronic headache, palpitation, dyspepsia and a dread of noises and trains, slight walks produce fatigue (all symbolic displacements dependent upon the channels of least resistance at the time of the psychic trauma). The love complex has become split off from the rest of his personality, it has become a disassociated personality, or a parasitic consciousness, and this mental conflict has caused temperamental changes, he is moody, irritable, sleepless, etc."

Now if this seems far fetched, let me remind you it is only a complicated case of the conditional reflex before noted. It is no more unreasonable that the man should develop a dread of noises heard at the moment of his psychic trauma, than that the dog should secrete gastric juice in response to the blowing of a whistle merely because that whistle has previously been blown when he was fed.

Further, this young man dreams and in his dreams the desires which he was unable to fulfill regarding his sweetheart will there be lived out in phantasy (wish fulfillment).

The psychoanalysts have come to place much importance upon dreams. They have found that the mind uses dream life to fulfill wishes and yearnings that are impossible of fulfillment with the social or ideal consciousness.

These dreams are often strangely disguised or distorted, and above all symbolic. Freud says that the stimulus to a dream is invariably some incident of the day preceding, and that starting back from this idea this chance association may be traced back thread by thread to the wish by taking each dream thought separately and having the patient in the waking state tell all the words or ideas associated with it.

One always meets the objection that dreams can't be wish fulfillments because they are often unpleasant, but let us remember that the wish manifested in the dream always originates in the unconscious. Conscious wish is a dream inciter only if it succeeds in arousing a similar unconscious wish which reinforces it. Now the unconscious is the instinctive or infantile desires, and the infantile mind is always egotistical. Every dream is absolutely egotistical; in every dream the beloved ego appears, even though it may be in the disguised form. This disguised form is made necessary by the social conscience or censor. As long as the disguise is complete there is no fear, but when the censor is partially or entirely overcome and the conflict in the mind is aroused we have fear. In other words, the distortion in dreams is to prevent fear and other forms of disagreeable emotion. The overpowering of the censor is made easier when fear has already been furnished by

stimulation from somatic sources, as in cases of persons suffering from pulmonary or heart disease where there is occasional difficulty in getting the breath, but even in these cases the somatic stimuli are used to aid those energetically suppressed wishes in attaining fulfillment in the form of a dream, the dreaming of which from psychic motives would have resulted in the same release of fear.

Closely related to fear dreams are anxiety dreams. Anxiety in dreams may be of a psycho-neurotic nature or it may originate in psychosexual excitements, in which case the anxiety corresponds to a repressed libido. Then this anxiety, as well as the whole anxiety dream, has the significance of a neurotic symptom, and we are at the dividing line where the wish-fulfilling tendency of dreams disappears.

Now just a word in regard to psychoanalysis. It may be defined as the reduction of an actual conscious content of a so-called accidental nature into its psychological determinants. It is not simply a deep and complicated form of anamnesis, it is not suggestion, it is not a method of reasoning with the patient.

Psychoanalysis endeavors to overcome the disorders of the neurotic through the subconscious and not through the conscious self. The patient himself does not know of the trouble existing in the subconscious and it must be revealed to him through a process of association requiring much study, much time and an infinite amount of tact and patience.

At the present stage only the true neuroses—neurasthenia and anxiety neurosis—and the psycho-neuroses—hysteria and obsessional neurosis—have been found suitable for this treatment. Whether such treatment will become applicable to the early stages of the psychoses remains to be seen.

In the meantime the studies of the neurotic and insane throw much light on the mental processes of the sane, for the mental mechanisms are the same. Just as we now view diseases of the body as a reaction to, say, an injury or an infecting organism, so we view mental disease as a reaction of the loosely knit neuropathic mind to conflicting emotions and desires.

The normal mind deals with the conflict between the pleasure-pain principle and reality in the full light of consciousness, and strives to adjust itself to reality; whereas the neuropathic mind suppresses into the unconscious the unpleasant facts and strives to obtain pleasure by regression to lower levels—to the infantile mode of dealing with life which is to find in phantasy what it misses in reality.

But it is not alone in the neuroses that psychoanalysis is applicable. It can be applied to normal individuals and thus establish a basis for the understanding of human conduct. It can be applied to the developing child and have as great a field in the prevention of psychic disorders and social ills as preventive medicine has had in the prevention of small-pox and malaria.

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The Relationship of Gastric Ulcer to Malignancy.

ALBERT SMITH, M.D., Parsons, Kansas.

Read before the Kansas Medical Society at Salina, Kansas, May 2, 3 and 4, 1917.

In discussing the relationship of gastric ulcer to gastric cancer, some authorities claim that gastric cancer never originates from gastric ulcer, while others claim gastric ulcer is a favorite habitat for the development of gastric cancer. Be that as it may, gastric cancer may originate from any irritation in the stomach.

In order to take up the differential diagnosis of gastric ulcer from gastric cancer and their relation to one another it will be necessary to give a few diagnostic symp-

toms of each. We will first discuss gastric ulcer.

Gastric ulcer is a very frequent and very fatal disease. Statistics would seem to indicate that nearly 25 per cent of both acute and chronic ulcers of the stomach, taken together, untreated surgically, are fatal. Of these 6 per cent die of perforation, 8 per cent of hemorrhage. Chronic ulcers are not infrequently followed by carcinoma of stomach and a large number die of tuberculosis.

The most frequent seat of gastric ulcer is upon the posterior wall along the pyloric half of the lesser curvature; a large number occur in the posterior wall of the body of the stomach, about 25 per cent in the pyloric portion and in the pyloris, 15 per cent in the lesser curvature of the stomach. About one ulcer in twenty occurs upon the anterior wall, yet perforation takes place more frequently here than elsewhere. Perforation of gastric ulcer may occur suddenly or gradually with results which are modified according to the anatomical site of the ulcer. Sudden perforation into the general peritoneal cavity with the escape of a large quantity of stomach contents produces peritoneal sepsis or diffuse peritonitis. The fatal accident is more likely to occur when the perforation takes place through the anterior wall of the stomach.

Hemorrhage occurs in a certain per cent of gastric ulcer cases. Moynihan's classification of hemorrhage from gastric ulcer divides them into four groups:

First—The hemorrhage is so small in amount as to escape observation with repeated microscopic and microchemical examinations of the stomach contents and feces.

Second—Repeated hemorrhages occur at irregular intervals, usually of several months, the amount of blood loss being considerable at each period. The patients have marked disturbances of gastric digestion and they become anemic.

Third — Hemorrhages considerable in amount and frequently repeated, occur in an individual who has long suffered from gastric disturbances.

Fourth — Bleeding occurs from one of the main arterial trunks of the stomach or other large vessel eroded during the process of the ulcer, such bleeding is sudden, continuous and uniformly fatal.

Cases of chronic ulcer without hemorrhage, in which the symptoms are those of chronic dyspepsia, accompanied by motor insufficiency of the stomach due to pyloric spasm or to actual narrowing of the pyloric orifice by cicatrical contraction or thickening and by a dilated stomach, are many in number.

A large ulcer in the body of the stomach may cause hour-glass contraction. One of the most valuable points of diagnosis is the history of the patient, such as attacks of digestive disturbances, extending over a period of years as a rule, and accompanied by excessive acid, pain, hemorrhage and, in the later stages, interference with the progress of food.

Acidity: At some time in the history of all ulcers the gastric secretions show an excess of hydrochloric acid. The finding of free hydrochloric acid in a fasting stomach and a few leukocytes often partially digested, are of great diagnostic value. Pain is the most common symptom of ulcer.

The differential diagnosis between ulcer of the stomach and duodenum can usually be made, the location of the pain to the right of the median line, the food distress coming on several hours after a meal are the important symptoms of duodenal ulcer. Microscopical examination of the food contents and the Roentgen ray are among the best means of diagnosis of gastric ulcer. In a certain per cent of chronic ulcer cases a tumefaction may be present without any malignancy.

Mr. Herbert Patterson, of London, is one of the noted gastric surgeons who does not agree as to the possibility of grafting malignant disease in simple ulcer of the stomach, while William J. Mayo, Moynihan, Wilson and others are of the opinion that gastric cancer can originate from gastric ulcer, Mayo stating that 71 per cent of cancers of the stomach have their origin

in simple ulcers. Futterer pointed out the relation of fishhook ulcer to gastric carcinoma and presented proof. Wilson and McCarty from the study of a large number of specimens showed that it was not the base but the overhanging margin of the ulcer that became carcinomatous.

Von Eiselsberg, of Vienna, has shown from the history of patients operated on in his clinic for gastric ulcer that 10 per cent have since died of cancer of the stomach, and later statistics of Von Eiselberg's clinic show that out of forty-one deaths following operation for gastric ulcer, 32 per cent were from gastric cancer. Recent data from other clinics show the same results.

Wilson has contributed to the theory that detached fragments of functionating gastric epithelium buried in the ulcer by scar tissue may have something to do with the starting point of cancer.

While all carcinomas of the stomach may not have their origin in ulcer, there is sufficient evidence to show that a preceding lesion in the gastric mucosa is nearly always present before carcinoma develops.

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American Veronal.

In the Trading with the Enemy Act recently passed by Congress, provision was made for the licensing of American manufacturers by the Federal Trade Commission to produce articles and substances patented in this country by enemy aliens. Already a number of chemical manufacturers have taken advantage of this provision, among them The Abbott Laboratories of Chicago, which has applied for and secured a license for the manufacture of Veronal, which, however, will be known hereafter by the name Barbital. This is the official name given it by the Federal Trade Commission, and this name must be used as the principal title by every firm manufacturing it under license from our Government.

The Abbott Laboratories have already begun the manufacture of Barbital (formerly known as Veronal), and we understand that in a short time it expects to have an abundant supply of this well known hypnotic, and that it will be made generally available through the trade. The quality of the product is guaranteed. Indeed, before a license is granted for the manufacture of any of these patented synthetics in the United States, the product must be submitted to rigid investigation at the hands of a chemist designated by the Federal Trade Commission. In this way Americans are assured of supplies of the American-made products at reasonable prices, and the manufacture of fine American chemicals is given the stimulus which it requires.

Those interested are urged to communicate with the Abbott Laboratories, Chicago.

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Beware of Swindlers.

No doubt you may have seen the several notices, under "General News" in the Journal A. M. A. in several recent issues, entitled "Once more a warning." These refer to swindlers operating in different sections of the country—various letters having been received from victims in Ohio, Colorado and other widely separated states. Now comes a letter from the well-known publishing house of W. B. Saunders Co., of Philadelphia, saying a man under the name of E. T. Rogers, claiming to represent the University Progressive Club of Cincinnati, for medical and other journals, has been victimizing physicians in Illinois; and the same subscription swindlers, or another under the name of Robert Wayne, has been relieving physicians of their well earned cash in the region of Gary, Indiana. It is believed there is concerted action, perhaps by an organized band, being taken at this time of the year, to victimize physicians on so-called "subscription" schemes. Every physician should decline to pay any money by check, or otherwise, to subscription agents not personally known to them, or for whom other physicians can not vouch. Many of these so-called agents operate under the guise of students "working their way through college."

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - - Editor

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Dues of Members in the Army Service Will Be Paid.

At the January meeting of the Council it was decided to appropriate the necessary funds to pay the annual dues of all members of the Society who are in active service with the army or navy. Secretaries of county societies, in making their returns to the secretary of the State Society, should include the names of all those in good standing in 1917 that are now in actual service, and should designate these names as of members in the service.

This does not apply to county society dues, but it is presumed that each society will be willing to suspend its dues for these men during the war.

Lecture Bureau Discontinued.

The Council, at its January meeting, also decided that the Lecture Bureau should be discontinued. The amount appropriated for the expenses of lecturers was exhausted and the benefits that were expected to be derived from the plan did not materialize. There has been no lack of demand for the services of the Bureau—in fact it has been difficult to supply lecturers for all the dates requested. The purpose behind the plan was to build up the weaker organizations and put them upon a good working foundation. It was hoped that a few meetings, with some of the well known men in the profession on the program, would increase the local interest in society work and increase the membership. The requests for lectures came very largely from the societies that were well organized and in good working condition. Most any of the men who have supplied lectures for the Bureau would very willingly respond to invitations from any of these societies and it seemed unnecessary that the State Society should carry the burden of expense.

The Council decided that the matter of supplying lecturers should be left with the Councillor of each district. If in his judgment a society organization may be improved by such help he is empowered to engage a lecturer for some meeting of that county and charge the expense to the State Society.

"Where the Offense Is, Let the Great Axe Fall."

By this time everyone will have read the stories of the mistreatment of sick soldiers in some of the cantonments that were made public by Senator Chamberlain. By this time everyone will also have read the reports of the courtmartial of two officers of the medical corps for neglect of duty. There will arise in many minds a question if these men are being made the goats in a very serious condition of affairs, for which the medical department, if at all, is not alone responsible.

If there are officers, of whatever rank, in the medical corps of the army, whose professional viewpoints have been camouflaged by their uniforms and shoulder ornaments, who forget their duty to the sick and injured in their disciplinary training as officers, who forget that their duty in this war is the same duty to suffering mankind that they assumed when they became members of the medical profession, such officers should not only be dismissed from the army, but should be deprived of their standing in the profession and of their right to practice among civilized people. But we are not ready to

admit, on any of the evidence so far made public, that there are any such.

There are few men in the medical profession who will accept any but the most positive and conclusive evidence on such charges as were made against these officers. There seems to be an impression that to be tried by courtmartial is to be convicted. Perhaps this is because only the cases of those who are convicted are made public; or, perhaps, it is because such a trial is only given when the evidence is conclusive. In the cases of the two officers mentioned there seemed, at least, no doubt in the minds of the court, nor in the mind of the Judge Advocate General who recommended that a prison sentence be added to that of dismissal. Nor does there seem to be any doubt in the mind of the Secretary of War, who said: "The department sets its face against that sort of callous disregard of soldiers' health. I want doctors and the country to know that their lives and the welfare are a responsibility which I will not permit to be dodged by handling in a cavalier fashion." There are men who are not quite so certain of the guilt of at least one of the officers who was tried and convicted by courtmartial. We quote the following from a letter, written by a man, not an officer, who had an opportunity to examine the transcript and to gain some facts which the newspapers have not made public:

"Dr. Dwyer was tried by court-martial November 27, for neglect of duty. He was charged with failing to examine Private Christie L. Gherring, who was reported on sick report the morning of October 17. The facts are, as shown by the transcript of the records of the court-martial, that Gherring reported for sick call on the morning of October 17. Lieut. Dwyer was in charge of the infirmary. Gherring was examined by two doctors who were assistants to Dr. Dwyer, and they reported that he was not sick and that they thought he was shamming. He was marked "duty" on the sick book by Dr. Dwyer. He went back to his barracks and was returned to the infirmary on the afternoon of the 18th, on a cot, when a diagnosis of pneumonia was made and he was sent to the base hospital, where he died three days later.

"Lieut. Dwyer was charged with neglect of duty because he failed to recognize and treat a case of pneumonia on the morning of October 17, which was the first morning Gherring reported at the infirmary. There is no evidence to show that Gherring had pneumonia at this time. The two doctors who examined him that morning said that he was not sick. His only complaint was that he felt weak in the knees. He had no temperature and his pulse was not accelerated.

"At this time the surgeons in Camp Funston were staying on duty night and day. It was no uncommon thing for them to not get through their work until three or four o'clock in the morning. On the morning of October 17, Infirmary No. 4 had 390 men on sick report, and on that day the doctors of that infirmary did over 700 inoculations, a fact which should be taken into consideration. The surgeons had been ordered by the brigade commander to be on the lookout for malingering, which was quite common among the men in the camp at that time, and no doubt influenced the doctors who examined Gherring, as they both say they thought he was shamming. And it is a fact that a man may be well, but shamming, on Tuesday, have pneumonia on Wednesday and die on Sunday, and no one be responsible for his death.

"Furthermore, the man who made the charges and fomented them was an undoubted degenerate and, in my opinion, was at this time insane. He later turned bandit, bank robber—robbed the bank in Camp Funston, murdered four men in the bank and afterward committed suicide—Capt. Lewis Whisler. The testimony of this man should certainly not be considered, and neither should the testimony of his sergeants be given any weight, as they were under his influence so completely, and in fear of their insane captain."

A slightly different version of this unfortunate case appears in a news item from Wichita, under date of January 30, published in the Kansas City Times, January 31, and is as follows:

"A local physician at Camp Funston is authority for the statement that Capt. Lewis J. Whisler, who robbed the Camp Funston Bank, killed four men, wounded another and then committed suicide January 12, was the cause of the court-martial and dismissal of Lieut. James G. Dwyer

on charges of mistreatment of a sick soldier who failed to properly salute him. According to the Wichita physician, Whisler altered a sick book after he had miscarried Lieut. Dwyer's orders regarding the sick soldier, who was ordered to the hospital by Dwyer. Whisler compelled the soldier to mop camp after he was too weak to stand and he fainted. When Dwyer visited the place the soldier couldn't get up. Whisler, the Wichita man says, was the chief witness against Dwyer, who maintained in court-martial that he was not guilty as charged."

The other case was that of Lieut. Chas. W. Cole, of Norton, Kansas, who was on duty at Camp Beauregard. In this case the evidence at the courtmartial showed that several sick soldiers had been transferred from regimental infirmaries to base hospitals, and that no immediate attention had been paid to them. They were not admitted but were kept in the ambulance. Afterward Lieut. Cole went out to see them and refused to receive them into the base hospital, ordering them returned to the infirmaries. Those who know Dr. Cole will not readily accept these bare statements as complete evidence in the case. They know that if he did not immediately give his attention to these sick men, it was because he was too busily engaged with other sick men, or some other equally good reason; and if he refused to receive them it was because there was no room in the hospital for them, or an equally good reason. Men, like Dr. Cole, who have practiced medicine for several years in Kansas, are not the kind of men to neglect the sick.

It would seem from current reports that the hospitals have been greatly overcrowded, and hospital attendants have not been supplied in sufficient number, or with sufficient training, to meet the requirements, and that the medical officers have been seriously overworked.

If these are facts, they are facts which the Secretary of War apparently did not know, but it is not to be expected that one who has such vast responsibilities should be able to keep in touch with the details of every camp. But there must be some one, higher in authority than a lieutenant in the medical corps, upon whom the responsibility for the conditions complained of does lie. Those who have read the letter of the father of the boy who died from meningitis will recall the statement that the boy was dirty, and that the attendant said they were allowed but one change of bed clothing each week. A boy, confined in one of the hospitals with measles, wrote to his parents that there were sixty patients in his ward and one ward master to care for them. Some of these patients had pneumonia and some of them died. The ward master was an enlisted man with no training for the duty he was detailed to perform. A nurse at the same camp wrote to a friend that she had charge of from forty-five to sixty cases and had an untrained ward master to assist her. A nurse at another base hospital wrote to another nurse that she had been working from eighteen to twenty hours a day, that she had had to take care of fifteen cases of pneumonia and that ten of them died.

What superlative loyalty the parents, the wives, the sweethearts of these boys have, who have known of these conditions for months yet made little if any complaint.

The dismissal, or imprisonment, of a few medical officers will not expiate the loss of life resulting from lack of hospital accommodations, lack of facilities for bathing and properly clothing these sick men, lack of trained attendants to care for their needs and lack of drug supplies for their treatment. Every medical man who is loyal to his country and loyal to his profession, whether in the army or out of it, will welcome the most searching investigation and the fixing of the blame where it belongs. It is to be hoped, however, that in any serious investigation that may be undertaken, for this time and for this purpose at least, the barriers of code will be let down and both officers and privates will be permitted to tell what they know without fear of reprimand or abatement of favor. Enlisted men, who are perfectly frank with their relatives and friends, are naturally cautious and conservative when

in harness with the reins of discipline in the hands of a martinet.

But in this army, which is made up of men from all walks of life, selected for their physical, their mental and their moral fitness, there is none but an arbitrary class distinction. In intelligence, in morality and in physical manhood, the enlisted men rank as high as the commissioned officers. Among these men are our future statesmen, our future governors, our future congressmen and senators, and our future presidents. The country is willing and able to give them the comforts of life. The medical profession is willing and able to give them the most efficient medical service that any army in any country in the world has ever had. An unprejudiced observer and conservative writer, Mary Roberts Rinehart, says of the medical corps, in her letter to Mr. Baker:

"Of cruelty and indifference, I have found nothing. On the contrary, I have found the medical staffs of the hospitals both efficient and humane. When it is remembered that the medical men of these national army hospitals are volunteers, who have cheerfully relinquished the results of years of labor to give their services to the country, that they are of the best we have, as all volunteers are, that they are willing to undergo deprivation and hardship, to take care of our boys, it is wrong that the country at large should so misjudge them.

"The best specialists of the country have placed themselves at the disposal of the army medical department, and ninety-nine out of a hundred men in the drafted army are receiving better care than they could afford, under the best circumstances, to receive at home."

The men who have volunteered their services in the medical department of the army are anxious to do their part in the war and they want to do it right. A persistently overworked man cannot be expected to be unerring in judgment. The most experienced and skillful physician cannot secure the best results without adequate facilities and competent nurses. No fault can be found with the medical organization of this army, it is a wonderful accomplishment. The trouble seems to be in its dependent relationship to other departments of the army. Congress may ultimately provide some relief for a situation in which the Surgeon General is permitted to recommend that hospital accommodations be increased, sewer systems established, and that men be not crowded in their tents, instead of having authority to see that such things are done. It may in time be so arranged that medical staffs are enabled to provide for their own requirements and have full control of their own accessories and activities.

Increased Popularity of Electricity and Radium.

Both of these remedial agents have passed through the "novelty" stage and are now being used and endorsed by hundreds of medical men of unquestioned standing and ability. Electricity and radium already have an important place in modern medical practice. But, without doubt, much is yet to be learned about their value in therapy.

If these two modalities can do even a part of what is claimed for them, then physicians should qualify themselves by reading, investigation and installation of equipment to use them in their practice, when indicated. The physician's obligations to his clients, no less than his duty to himself, require this.

In addition to the many and varied uses for which physicians have found electricity of value in medical science, they are now employing it extensively for commercial purposes, such as electric vehicles, lighting and telephone systems for offices, homes, sanitariums, hospitals and public institutions.

Radium is coming into use more and more by physicians, particularly in sanitariums and hospitals. In many internal, as well as external, conditions, radium is recognized as an important therapeutic agent.

The editorial staff of this Journal—your Journal—is in full sympathy with this movement, and invites frequent contributions in the way of case reports, discussions, and other clinical notes for publica-

tion. It is also hoped that arrangements can be made for having at least one paper on each of these subjects for our next, as well as subsequent, annual state meetings.

The more progressive manufacturers, some of whom are listed below, have rendered valuable service to the profession by collecting clinical data and publishing it in the form of reprints for free distribution to interested physicians. The reprints are, of course, in addition to their regular catalog literature, and may be obtained for the asking.

Victor Electric Corporation, 236 South Robey Street, Chicago.

Frank S. Betz Co., Hammond, Ind.

Merry Optical Co., Merry Bldg., Kansas City, Mo.

Radium Chemical Co., Pittsburgh, Pa.

Campbell X-Ray Co., 612 East Ninth Street, Kansas City, Mo.

Hettinger Bros. Manufacturing Co., Tenth and Grand, Kansas City, Mo.

Physicians Supply Co., 1021 Grand Avenue, Kansas City, Mo.

O. H. Gerry Optical Co., Kansas City, Missouri.

Columbian Optical Co., Kansas City, Mo.

Principal Causes of the Rejection at Camps of Men Passed by the Local Board Surgeons.

At one time there was a tendency to criticize the doctors on the examining boards for carelessness, it being claimed that a large per cent of those sent to camp were rejected by the army surgeons at camp. It is a great satisfaction therefore to find the exoneration of these men coming from an authoritative source. The following appeared in the Bulletin of January 11:

The Provost Marshal General, in his report on the operation of the selective-service act, says:

Rumors here and there in the public press stated that the camp surgeons had discovered, among the men accepted by the local boards, some with glass eyes, some with cork legs, and some with other obvious disqualifications. If such men were found, no disparagement is involved for the local-board surgeons; for it is safe to assert that such grossly defective persons came from the contingent of about 20,000 men who had never appeared before the local boards, but had been gathered up by the adjutants general and sent direct to the camps. There is no ground for supposing that the local-board surgeons were either incompetent or careless to that extent. The spirit of their practice was to make all intendments in favor of the Government; but nothing permits us to suppose that they would or did send to camp any men with cork legs or glass eyes.

PERCENTAGES OF REJECTIONS.

Doubtless the local boards varied extremely in the strictness of their examinations. But so also, it seems, did the camp surgeons. The table shows that the percentage of rejections at camp varied between 0.72 per cent and 11.87 per cent; and as the physical condition of the men from the different regions can not entirely account for this, it must be attributable in part to differences of strictness in the examinations by the camp surgeons.

But were the Surgeon General's rules for physical examination, as set forth in the directions to the local boards, stricter than necessary for securing efficient fighting men? On this point the civilian surgeons have expressed variant opinions. A large majority consider that the physical requirements are not too exacting. But a considerable number deem the requirements too strict in many respects, notably as to the weight-and-height relation, teeth, eyes, and feet, and contend that the regulations as strictly applied tend to exclude many capable and efficient men. For example, one board cited a case of exclusion for flat-foot of a man who had for many consecutive seasons endured the hardships of a guide's vocation in the Canadian forests; and the prevalence of flat-foot among sturdy negroes of the South was frequently commented on.

Was there any extensive attempt at deception of the local board surgeons by registrants called for examination?

FEW ATTEMPTS AT DECEPTION.

It is gratifying to report that falsification was attempted to only a slight and negligible extent. Here and there a board reports a locality as showing 50 per cent of attempted falsification; but these instances were sporadic, and represent only some local obliquity of morals.

Of the various grounds for rejection, which were the most common? It must be left to the future to study accurately the valuable mass of data now latent in the records. Time has sufficed only to examine a small group of the records of rejections; 10,000 men were represented, spread over eight camps. The specific source of defect showing the largest percentage was eyes; and the next largest, teeth.

The Training Camps.

Some of the men who have applied for commissions in the Medical Officers' Reserve Corps, and some of those who anticipate making application, are losing enthusiasm on account of certain reports that are said to have come from the training camps. One of these reports, now frequently heard, is to the effect that the men in the training camps spend all their time in company drills, and have no clinics or opportunity for instruction in the real medical work of the army. This may be a disappointment to many of the men, but if true should not be discouraging. If one may judge from the appearance of the men who have been through this training course, they have been greatly benefited by it. From the nature of our work as practitioners most of us get soft, some of us fat, all of us showing too early the little disturbances of function which come from too much worry and too little physical exercise. This period of training has made a remarkable change in such men. A glance at one of them shows that he has a vigorous and healthy appearance that he did not have before. His circulation is no longer sluggish, his respiration no longer shallow; his muscles now feel like iron and his appetite and digestion are irreproachable. His intellect is clearer, his resistance is increased and his endurance extended. In other words he has had a few months of the right kind of vacation for a professional man and during that time he has been specially fitted for the strenuous life and arduous duties he will be required to meet when he gets into the war zone.

Another report which has added somewhat to the uneasiness of the newly commissioned is that many of the men are assigned to duty as Sanitary Officers, in which capacity their knowledge of medicine is of little use, and in which the duties could be as well performed by any of the enlisted men. It is well to keep in mind the fact that this is all preparatory work being done here and, while we do not know it to be so, we can imagine that it is necessary to assign some of the medical officers to minor duties now in order that there may be a sufficient number for the work to be done "over there." It is safe to say that every man in the medical corps will have ample opportunity to prove his skill in medicine or surgery when our army gets into action.

Opposed to the Tax.

The following is a copy of a resolution unanimously adopted by the Council of the Ohio State Medical Association, at the regular quarterly meeting held in Columbus, Monday, January 7, 1918:

"Resolved by the Council of the Ohio State Medical Association, after a careful investigation of Section 209 of the War Revenue Law: That that provision is entirely unfair, and works a serious injustice to professional men, this injustice being more particularly marked in the case of physicians, who without exception have always done a large amount of charity work, and who in particular as the result of the war have had increased work with lessened incomes:

"That the tax is particularly obnoxious because it imposes a special burden upon men who earn their incomes, while it exempts from that burden owners of inherited wealth who earn nothing but are sim-

ply parasites;

"That we, therefore, call upon our representatives in Congress to use their utmost endeavors to secure a repeal of this unjust and onerous tax which, so far as we can learn, has not been imposed, or even contemplated, in any of the other countries engaged in the present war."

Hospital Is Well Supplied Now

The following item, dated Camp Doniphan, February 1, appeared in the Kansas City Times of February 2:

"The supplies at the base hospital have been coming in at such a rate that new men sent there will not have to take their own mess kits and blankets. An order was issued today by division headquarters that all the men needed to take was toilet articles."

Military Anti-Tuberculosis Program Perfected.

Plans for a complete program for the prevention of tuberculosis in the army have been perfected by the National Association for the Study and Prevention of Tuberculosis working in co-operation with the Surgeon General, the Y. M. C. A., and other agencies. This, it is predicted, will put the impending second draft on a better health basis than the first. The program will include not only a follow-up for every man discharged on account of tuberculosis, but a thorough-going health educational campaign among the soldiers.

Prior to the first draft the National Association began to outline a preventive campaign. Owing to the magnitude of the task and the many practical delays in perfecting and applying the details of this scheme, the results were not as encouraging as might be expected. This was due to the fact that the report of names of men rejected by the draft on account of tuberculosis was inadequate, the slowness of the machinery in getting under way, and the many difficulties in determining the status of the men.

Inasmuch as these enlisted or drafted men do not become accepted soldiers until after their probationary period lasting from three to six months in the various services, the Government assumes no responsibility for the after-care of those whose health breaks down during that period. Hence, this problem belongs to the civilian boards of health and the unofficial health organizations.

The National Association program falls into two main divisions: (*a*) follow-up work and (*b*) educational work. The first obstacle to the follow-up program was Section 11 of the Selective Service Regulations regarding the second draft which forbids giving a record of a man's condition to anyone except certain designated officials. The National Association officers, however, placed before the War Department the importance of this work and were influential in persuading them to open the records of rejected men to state and local boards of health throughout the country, through the United States Public Health Service and the Council of National Defense.

Inasmuch as the above section of the regulations does not apply to men dismissed from training camps after they have passed draft boards, the Association arranged with the Surgeon General and the division surgeons in camps to receive the names of all men thus dismissed. These lists are divided up by states and forwarded to state associations and state boards of health for follow-up work. Where men are referred to localities where there are not at present facilities for this follow-up work, the Association will use its good offices to promote the establishing of such facilities.

In the meantime, the Medical Department of the Army has perfected its machinery for weeding out these tuberculosis cases. Every man passed by the draft board after going into camp is examined by the regimental surgeon, re-examined by a tuberculosis board and then if suspected of tuberculosis, again examined by a tuberculosis expert. This follows a general policy mapped out and recommended by the National Association.

A large number of men have already been accepted into the service who were known to be tuberculous, many of them formerly inmates of tuberculosis sanitaria. Part of the Association's work has been to get in touch with every tuberculosis sanatorium and dispensary in the country and compile lists of all recent male inmates of draft age, giving the history of their cases and whether or not it was known if they were in the army at present. Hundreds of such names have already been received. This data is forwarded to the training camps, the men are located and the results are reported back to the sources of information.

Furthermore, the Association has sent a letter to all of its fifteen hundred local co-operating agencies giving the provisions of the second draft and urging that these agencies procure the names and addresses of all the men of military age in their section who are known to have tuberculosis; get in touch with these men and arm them with the necessary affidavits to prevent, if possible, their being passed by the draft board, and recommend to the local draft boards the names of the approved tuberculosis experts in their section.

The Association is also co-operating with the Surgeon General's office to aid the Government in providing sanatoria for those men who have been discharged from the service on account of tuberculosis after their probationary period has expired. All full-fledged soldiers and sailors returned from France or other stations will be cared for as near to their own homes as possible in sanatoria accommodations provided by the Government. The Government intends to utilize as far as possible existing institutions.

From the United States Marine Corps the National Association has secured each month a report of men rejected for tuberculosis from all its recruiting stations, and these men will receive the regular follow-up attention.

From the second or educational division of the program it is hoped to derive the greater ultimate good by the establishment of fundamental preventive measures among the well.

The National Association is interested in any kind of an educational campaign among the men in the various military camps that will tend to promote interest and information with regard to the control and prevention of communicable diseases, and toward the promotion of public and individual health in general. In the mobilization of such large numbers of men in various camps throughout the United States there have developed an unusual number of somewhat serious epidemics of colds, coughs, pneumonia, measles and various other respiratory and communicable diseases. That all of these diseases can be controlled by education and by the exercise of adequate public health measures has been clearly demonstrated in the civilian population throughout the United States. Most of these epidemics are spread through ignorance and carelessness. It is inevitable where large numbers of men from all walks of life and with all possible diseases and variations of physical habits are thrown together in somewhat uncomfortable and crowded living conditions, that there will be an immediate increase in the amount of sickness from communicable diseases. It must be obvious, however, to even the most superficial observer, that if these men can be taught to maintain a reasonable standard of personal hygiene and can be given a knowledge of the methods and principles of the control of communicable diseases a rapid diminution in the sickness rate will follow.

In co-operation with the Educational Committee of the National War Work Council of the Y. M. C. A., the National Association will furnish a number of stock lectures dealing with tuberculosis together with lantern slides to illustrate them. It will also arrange to put the educational secretaries of each of the camps in touch with public lecturers in and around their respective camps. The Association has requested the War Department to give careful consideration to the desirability of appointing one or more special officers de-

tailed to lecture on tuberculosis and allied health subjects in all of the army camps throughout the country.

The Association has prepared a special circular entitled "Red Blood," giving in brief and attractive form a message to the soldier relative to personal fitness, a health "Don't Card"; and a Public Health Manual may also be distributed, the latter being a text book of personal hygiene.

The Association will also arrange to distribute through the departmental executives of the Y. M. C. A. a number of special tuberculosis exhibits known popularly as "The Parcel Post Exhibit." In connection with these, moving picture films and lantern slides will be used.

The National Association Field Secretary, Dr. Pattison, is visiting the training camps and supervising this educational work.

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Mobilizing the Profession far War.

Until the entire medical profession of the United States, or at least those who are mentally and physically fit and within the age limit, are mobilized within the Medical Reserve Corps of the United States Army, not until then can we give to the Surgeon General that efficiency which he so badly needs in having a large body of medical officers upon whom to draw.

You may never be called, at the same time your joining the Medical Reserve Corps and placing your services at the command of your country, clearly indicates the patriotism which the medical profession, as a whole, should evince and which we must manifest if we are to win the war.

Every doctor must realize that success depends upon a carefully selected and thoroughly trained body of medical officers. By careful selection, we mean the placing of a medical officer in a position where he is best fitted for the service, and only by having an immense corps or the entire profession mobilized upon a war basis can we serve our country to the best possible advantage.

This mobilization of the entire profession should come from within the body itself, but every physician coming within the requirements of the service, as to age and physical fitness, should seriously consider this suggestion and not wait for complete mobilization but apply at once for a commission in the Medical Reserve Corps of the United States Army.

It is not only for the combatant forces that medical officers are required, but for sanitation, hospital camps, cantonments and in other departments where the health and life of the forces are dependent upon the medical officer.

We have within the profession a sufficient number of doctors to fully meet the requirements of the Surgeon General's office, whatever they might be, but to be of service, you must join the Medical Reserve Corps to enable you to meet the appeal which is now being made for a large and efficient Medical Reserve Corps upon which the Surgeon General may draw as requirements demand.

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Dr. E. H. Skinner, of Kansas City, Missouri, who has been conducting a school of instruction in Roentgenology for officers of the medical corps of the army, has recently been called into active service. Dr. O. W. Swope, who has recently been associated with him, will conduct his X-Ray laboratory during the absence of Dr. Skinner.

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According to an item appearing in the Kansas City papers the Grandview Sanitarium was seriously damaged by fire about the last of January. It was owned by Dr. S. S. Glasscock and was one of the largest and finest institutions of its kind in the West.

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News has been received of the death of Dr. Herbert Arnold Van Duyn, Hill City. Dr. Van Duyn was 46 years old, a graduate of the College of Physicians and Surgeons, Chicago, 1893. He was commissioned a Lieutenant in the M. O. R. C., September 28, 1917. He died at Hill City on January 28, 1918, and was buried at Middleport, Ohio.

According to reports received the Missouri Building in Kansas City, occupied by the Physicians Supply Co., has been completely destroyed by fire. The stock of instruments and supplied was very large.

SOCIETY NOTES.

FRANKLIN COUNTY SOCIETY.

The Franklin County Medical Society met at the office of Dr. J. B. Davis. The annual election of officers resulted as follows: President, Dr. S. D. E. Woods, Princeton, Kansas; vice president, Dr. H. B. Johnson, Pomona, Kansas; secretary, Dr. H. L. Kennedy, 322 South Main Street, Ottawa, Kansas. The annual banquet which has been held by the Franklin County Society each year was postponed this year on account of the war.

H. L. KENNEDY, M.D., Secretary.

—3—

PRATT COUNTY SOCIETY.

At our meeting of January 7, the following officers were elected: M. C. Jenkins, president, Pratt; G. E. Martin, vice president, Cullison; C. H. Fain, secretary, Pratt.

G. W. Maness, of Preston, joined our Society and also has received a commission in the Reserve Corps.

Dr. C. E. Phillips, of Zenda, Kansas, has moved to Pratt and transferred his membership from Kingman County to Pratt County.

M. C. JENKINS.

—3—

DOUGLAS COUNTY SOCIETY.

The Douglas County Medical Society met in regular session in the Chamber of Commerce rooms in Lawrence, on January 8. The following officers were duly elected for the ensuing year: Dr. Geo. M. Liston, of Baldwin, president; Dr. C. E. Orelup, of Lawrence, vice president; Dr. W. C. McConnell, of Lawrence, secretary; Dr. E. M. Owen, of Lawrence, treasurer; Dr. J. B. Henry, of Lawrence, censor.

The Douglas County Society is in the best working order that it has been for some years, which condition is largely due to the efficient work of the retiring president, Dr. E. J. Blair, who made a rousing speech in response to a vote of thanks by the Society.

W. C. MCCONNELL, Secretary.

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ALLEN COUNTY SOCIETY.

At the December meeting of the Allen County Medical Society Dr. R. O. Christion of Iola was elected president, Dr. W. R. Heylmun was elected vice president, Dr. J. G. Walker was elected secretary, Dr. A. J. Fulton, treasurer, and Dr. F. S. Mitchell for delegate.

J. G. WALKER, Secretary.

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BOURBON COUNTY SOCIETY.

At the December meeting of the Barton County Medical Society, officers for 1918 were elected as follows: President, H. C. Embry, Hoisington; vice president, A. H. Connett, Great Bend; secretary and treasurer, T. J. Brown, Hoisington; censors, E. E. Morrison and A. Kendall, Great Bend; delegates to state convention, M. F. Russell and E. C. Button, Great Bend.

T. J. BROWN, M.D., Secretary.

MISCELLANEOUS

The so-called fractional method of gastric analysis advocated by Rehfuss has been found to have such advantages that it has been introduced in the Battle Creek Sanitarium, where test meals to the number of thousands were given each year. To the patients, the new plan is vastly preferable. Indeed, the swallowing of what was often called "the garden hose" was attended in most cases by actual suffering and in many by severe pain. Under the fractional method, a very small tube is used. An oval tip, made of metal and perforated, makes the swallowing easy. Of course it is inconvenient to have to sit for an hour and a half or two hours without removing the tube, but there is no real distress. The usual test meal of two slices of toast and a glass of water is given, at intervals of half an hour, a small specimen of the gastric juice, ten or sixteen c.c., is taken,

until the acidity curve begins definitely to come down.

Under the old method the practice was to take out all the gastric juice at the end of an hour. At Battle Creek the period has been lengthened to an hour and a quarter because this was found to be the usual time of greatest acidity. A comparison of the two methods shows that the original plan was misleading in many instances. Under that procedure, cases would be set down as normal if the acidity was shown to be at the usual percentage one hour after the meal. However, as the fractional method proves, many patients who have the right acidity at that minute may have far too little or too much before and after the hour has passed. By studying the complete cycle of digestion an accurate diagnosis may be made.

Scope of Medical Training Being Extended at Camps

Extensions are being made to the scope of the medical training camps at Fort Oglethorpe, Ga., and Fort Riley, Kansas, by the addition of courses in specialties required of the Medical, Sanitary, and Veterinary Corps under Surg. Gen, Gorgas. There are at present 5,400 officers and men under training at Fort Oglethorpe and 3,800 at Fort Riley. Fort Riley has a capacity of 7,000. Enlargement of the school at Fort Oglethorpe to the same capacity has been authorized, its present capacity being 5,500. The ultimate needs of the Medical Department of the Army look to training camps of capacities totaling 35,000 to 40,000 officers and men.

NEARLY THIRTY THOUSAND GRADUATES.

There have been graduated from medical training camps since June 1, or are now under instruction, a total of about 9,000 officers and about 20,000 enlisted men since June 1. Until December 1 the medical training camp at Fort Benjamin Harrison, Indiana, and the one at Fort Des Moines, Iowa, for colored officers and men, had been contributing to the total, but these camps have been discontinued.

Ten new sections have recently been or are now being established for officers in the medical training camps. These are for the following:

(1) X-ray specialists; (2) orthopedic surgeons; (3) psychologists; (4) special examining surgeons; (5) sanitary engineers; (6) veterinarians; (7) sanitarians; (8) hospital administration; (9) laboratory specialists (being established); (10) dental surgeons (being established).

THREE ADDITIONAL COURSES.

Consideration is being given to plans for the establishment of three additional courses, one in general military surgery, one for genito-urinary surgery, and one for military surgery of the brain, head, and face.

Various special groups now in active service have been trained since the opening of the schools. These include officers and men to operate ambulance companies, field hospitals, evacuation hospitals, base hospitals, hospital trains, etc. — Bulletin, January 22.

Bulletin on Meningitis.

At this season of the year, when cerebrospinal fever prevails, and there are more or less outbreaks of this dreaded disease throughout the United States, a bulletin on the diagnosis and treatment, which has been recently published by the Mulford Company, a copy of which is being forwarded to you, will no doubt be of much interest. Our text-books and other books of reference are not complete, and this brochure will be found to embrace information secured from hospitals, both military and naval, boards of health and information generally obtained from the entire world.

The comprehensive information on symptoms, diagnosis, treatment, carriers and culture, should prove of the greatest value to every physician, and especially those who are associated with and have care of army and navy camps and cantonments, as the occurrence of spinal meningitis is of more or less frequency, and is found to be most difficult to control.

Reporting of Accidents from Local Anesthetics.

To the Editor: The Committee on Therapeutic Research of the Council of Pharmacy and Chemistry of the American Medical Association has undertaken a study of the accidents following the clinical use of local anesthetics, especially those following ordinary therapeutic doses. It is hoped that this study may lead to a better understanding of the cause of such accidents, and consequently to methods of avoiding them, or, at least, of treating them successfully when they occur.

It is becoming apparent that several of the local anesthetics, if not all of those in general use, are prone to cause death or symptoms of severe poisoning in a small percentage of those cases in which the dose used has been hitherto considered quite safe.

The infrequent occurrence of these accidents and their production by relatively small doses point to a peculiar hypersensitiveness on the part of those in whom the accidents occur. The data necessary for a study of these accidents are at present wholly insufficient, especially since the symptoms described in most of the cases are quite different from those commonly observed in animals even after the administration of toxic, but not fatal, doses.

Such accidents are seldom reported in detail in the medical literature, partly because physicians and dentists fear that they may be held to blame should they report them; partly, perhaps, because they have failed to appreciate the importance of the matter from the standpoint of the protection of the public.

It is evident that a broader view should prevail, and that physicians should be informed regarding the conditions under which such accidents occur in order that they may be avoided. It is also evident that the best protection against such unjust accusations, and the best means of preventing such accidents consist in the publication of careful detailed records when they have occurred, with the attending circumstances. These should be reported in the medical or dental journals when possible; but when, for any reason, this seems undesirable, a confidential report may be filed with Dr. R. A. Hatcher, 414 East Twenty-sixth Street, New York City, who has been appointed by the committee to collect this information.

If desired, such reports will be considered strictly confidential so far as the name of the patient and that of the medical attendant are concerned and such information will be used solely as a means of studying the problem of toxicity of this class of agents, unless permission is given to use the name.

All available facts, both public and private, should be included in these reports, but the following data are especially to be desired in those cases in which more detailed reports cannot be made:

The age, sex, and general history of the patient should be given in as great detail as possible. The state of the nervous system appears to be of especial importance. The dosage employed should be stated as accurately as possible; also the concentration of the solution employed, the site of the injection (whether intramuscular, perineural or strictly subcutaneous), and whether applied to the mouth, nose, or other part of the body. The possibility of an injection having been made into a small vein during intramuscular injection or into the gums should be considered. In such cases the action begins almost at once, that is, within a few seconds.

The previous condition of the heart and respiration should be reported if possible; and, of course, the effects of the drug on the heart and respiration, as well as the duration of the symptoms, should be recorded. If antidotes are employed, their nature and dosage should be stated, together with the character and time of appearance of the effects induced by the antidotes. It is important to state whether antidotes were administered orally, or by subcutaneous, intramuscular or intravenous injection, and the concentration in which such antidotes were used.

While such detailed information, to-

gether with any other available data, are desirable, it is not to be understood that the inability to supply such details should prevent the publication of reports of poisoning, however meager the data, so long as accuracy is observed.

The committee urges on all anesthetists, surgeons, physicians and dentists the making of such reports as a public duty; it asks that they read this appeal with especial attention of the character of observations desired.

TORALD SOLLMANN, Chairman
R. A. HATCHER, Special Referee
Therapeutic Research Committee of the Council on Pharmacy and Chemistry of the American Medical Association.

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Saving the Children.

The lives of one hundred thousand of the nation's children are to be saved in a child welfare drive which the Federal Children's Bureau has announced today. The drive will begin on April 6, one year from the day the United States declared war, and the first day of the Children's Year.

Public health authorities agree that half the deaths of young children are easily preventable. Each state will be assigned a definite quota of the hundred thousand lives to save. State councils of defense and the state women's committees are being called upon to be responsible for the state quotas.

Methods of work will be those which have already been proved efficient in saving children's lives in the United States and other warring countries.

To inaugurate the Children's Year a nation-wide weighing and measuring of babies and children of pre-school age will be made. No such general test of the well-being of children has ever been attempted. It will show each community what its children need if the men of the rising generation are to be free from the physical defects which the draft has revealed.

The plans contemplate economy for every purpose except for the essential means of protecting child life.

Rest in the Treatment of Tuberculosis.

J. H. Pratt, of Boston, in a paper read before the American Medical Association, June, 1917, published in the American Review of Tuberculosis for January, reviews the history of the rest treatment of tuberculosis, describes his own application of this treatment and compares his results with those of others. Brehmer was one of the first men to treat consumption successfully and while he is known as the advocate of exercise as a means of cure his treatment was in reality a modified rest treatment in which the patients were most carefully guarded against overexertion. His patient and assistant Dettweiler used reclining chairs in the open air for prolonged periods and attributed his success to the open air rather than to the rest of lungs and body. He recognized the fact that "absolute rest" was the most valuable treatment in combating the fever of phthisis. Trudeau, learning of the work of Brehmer and of Dettweiler through an English journal, began work along similar lines at Saranac, in 1885, and his experience made him a firm advocate of the rest treatment. Independently, Kretzschmar, of Brooklyn, published in 1888 an excellent account of the Dettweiler method of treatment and urged the erection near New York of a proper sanatorium for the introduction of this therapy. In Germany the importance of rest was even more fully recognized by Turban, Cornet and Penzoldt, but in this country the influence of Dettweiler was slight despite the work of Trudeau, Minor and a few others. The treatment generally advocated here was exercise in the open air on the theory that the tuberculosis was favorably influenced by the "auto-inoculation" induced by labor. Even the advocates of this treatment at the Brompton Hospital Sanatorium have been disappointed in the results. The studies of Barnes, of the Rhode Island Sanatorium, indicated that the mild febrile auto-inoculations were injurious. Nothing could indicate more clearly the failure to recognize the importance of rest by those in charge of the tuberculosis campaign

than a pamphlet of the New York State Department of Health, which states under "How to treat and cure tuberculosis": "It it well to rest for half an hour or if possible a little more, before and after each meal." Or the Red Cross test book on hygiene and home care of the sick in which the reader is told that "a dry climate and an outdoor life with abundant, nourishing food cover the special treatment" of tuberculosis.

Tendeloo ascribed the benefits of rest to the fact that with diminution of respiratory movements the lymph flow falls almost to zero, the nutrition of the affected area is shut off, tuberculous toxins and products of disintegrations accumulate in it until the growth of bacilli and production of toxin ceases. Rubel showed in rabbits that after intravenous injections the tuberculous process was more benign and chronic in the lung kept at comparative rest than in the freely moving lung. Krause has stressed the importance of mechanical walling off of foci by scar tissue. Injury from exercise cannot always be detected with the most careful supervision until it is too late to prevent renewed activity. On this basis the more complete the rest the shorter will be the duration of treatment and the greater the probability of recovery. According to Pratt there should be complete physical and mental rest in bed out of doors, in the recumbent or semi-recumbent position with as complete elimination as possible of all activity or excitement. The duration of this period depends more upon the severity or extent of the disease in the lungs at the time the treatment is begun than on the extent and rapidity of the improvement during the first weeks of treatment. Unnecessary delay in starting exercise will do no positive harm. Patients with fever should be given typhoid rest treatment. It may be necessary to eliminate every motion except the handling of the sputum box. Exercise should not be begun until several weeks after the temperature has reached normal, as shown by the two hourly temperatures between 8 a.m. and 8 p.m. on several successive days. When exercise is begun the allotted amount should be taken every other day, as recommended by Brown, to allow of more ready detection of injury from overexertion. Exercise is given not as treatment but to make the rest less dull, to encourage the patient and prepare him for a return to a normal life.

Objections to the rest treatment are easily met. Those that have been accused of overdoing the rest treatment are now more than ever insistent upon its advantages. Pratt himself has used more prolonged rest than any other writer and the result has been a larger percentage of recoveries. It is suggested that different patients need different treatment. It would be as logical to make similar distinctions among patients ill with typhoid fever or with pneumonia. The objection that rest may weaken the heart is purely theoretical and not borne out by facts. No industrious person may ever be converted by the rest treatment into a lazy loafer. The contention that the rest treatment makes patients nervous and depressed is not borne out by Pratt's experience.

Pratt compares the results of this rest treatment of the Emanuel Church tuberculosis class with those of the treatment with graduated exercise at the Brompton Hospital Sanatorium. The class consisted of unselected cases of whom 36 per cent were far advanced supervised by the class method. The average duration of bed rest was about four months and the duration of graduated exercise combined with bed rest four to seven months. For comparison of results those have been selected in which the wage earning power had been restored while under treatment the comparison shows that prolonged rest leads to permanent recovery in a large proportion of the cases treated and that strengthening a man's muscles and improving his general condition by graded work does not heal the tuberculosis process in the lungs. The comparison is in favor of the class despite the generally recognized difficulties of home treatment.

Pratt concludes that the failure to cure

pulmonary tuberculosis is not due to the incurability of the disease but to the fact that the proper treatment has not been employed. Tuberculosis can be cured in and out of sanatoria in a large proportion of cases by the strict rest treatment. As the most complete rest can only be obtained in bed it is evident that bed rest out of doors should yield a larger percentage of recoveries in a shorter period of time than any other known method.—Pratt, J. H.: The Importance of Long Continued Rest in the Treatment of Pulmonary Tuberculosis, Am. Rev. Tub., January, 1918, I, 637.

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Measles and German Measles in the Army Camps.

While much is said regarding measles (morbilli) in the army camps, it seems to be less generally realized that German measles (rubeola) also is prevalent. Rubeola is practically never fatal and complications are rare, whereas measles is often accompanied by most serious complications (bronchopneumonia, otitis media), besides leaving the subject, if he recovers, strongly predisposed to tuberculosis. Many who have suffered from measles in the army camps also have suffered from bronchopneumonia due either to streptococci or pneumococci. A number have died, and for those that have recovered from the complicating pneumonia, convalescence has been in many instances delayed by an empyemic sequel. The differentiation of morbilli from rubeola, though difficult in single instances, is in the majority of cases a relatively easy matter to the closely observant physician. In measles, the prodromal stage with its catarrhal symptoms (coryza, photophobia, conjunctivitis and cough) is, in itself, fairly characteristic; and when the disease is epidemic, such catarrhal symptoms should at once excite suspicion. The preceding incubatory leukopenia with relative lymphocytosis and eosinopenia is of some diagnostic importance. Above all, the pathognomonic "Koplik's spots," small, slightly elevated, white or bluish white, sharply circumscribed white spots, the size of the head of a pin or smaller, surrounded by a narrow hyperemic zone, should be sought for on the buccal mucous membrane —opposite the molar teeth, inside the lips, or at the junction of the gums with the cheeks. They are present in six out of every seven cases of morbilli, and are visible in the prodromal stage. Again, the maculopapular eruption of morbilli, once it has appeared, is very characteristic. It comes first on the face and scalp, often in front of and behind the ears, and extends to the neck, upper trunk and arms, and, later, to the lower trunk, buttocks and thighs, requiring from two to two and a half days after its first appearance for its full development. At first it is pink, but soon it turns darker red and often brownish red. As von Pirquet has shown, the times of appearance of the rash on the different parts of the body stand in definite relations to the cutaneous arterial supply; the rash appears earliest on parts of the skin in which the arterial distance from the heart is least and the circulation liveliest. The crescentic grouping of the maculopapular eruption is often striking. In rubeola, or German measles, the prodromes are mild or absent, Koplik's spots are not present, the rash is macular rather than papular, it is of a lighter rose red, and its macules are rarely confluent. Beginning on the face or scalp, it extends (in crops) over the rest of the body in about twenty-four hours. In a few instances, the rash resembles that of measles; more often it could be confused with that of scalret fever.—Jour. A. M. A., Feb. 2, 1918.

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Psychopathic Hospitals.

After mentioning the stigma popularly attached to insanity, Richard Dewey, Wauwatosa, Wis. (Journal A. M. A., Feb. 2, 1918), advocates a law placing the patient within the walls of the primary detentional or psychopathic hospital and putting in operation through the action of the court itself or at regular stated intervals a method of inquiry personally addressed to each patient which will give him the op-

portunity of saying whether he remains in the hospital of his own free will or wishes his liberty. Dewey believes that by this method all cases really requiring legal assistance would naturally come to light, and in most of them it would be found that there would be no occasion for court inquiry. He believes that in all communities a psychopathic or detention hospital should be utilized and patients admitted in the same manner as those admitted to other hospitals, and freely discharged as well, except in cases when they are in a condi- and for others that they should be at tion in which it is unsafe for themselves large. They should be free to go and come, if they are capable of doing so. No so-called ban or stigma should be placed on them, on account of mental illness, any more than on account of physical illness.

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Lung Abscess.

W. D. Tewksbury, Washington, D. C. (Journal A. M. A., Feb. 2, 1918), refers to a former paper in the Journal in which he described a case treated by artificial pneumothorax, which he considered a new method at the time, and states that he has received a large number of letters from physicians treating abscess of the lung. In Washington alone during the past year he has seen fifteen cases following operations on the nose and throat. Hence he thinks the condition is less infrequent than has been supposed. In the present article he aims to consider only cases following operation on the nose and throat. The infection is of the usual mixed type with the staphylococcus and the streptococcus predominating. There are two theories as to the mode of infection: first, that the infecting organisms are carried into the lung by the direct aspiration of infected blood during the anesthesia, and second, that they are carried by infected clots with a resulting septic infarct. The symptoms appear from four to ten days after operation and begin with a rise of temperature, dry cough, pain in the chest on the af-

(Continued on Page xv)

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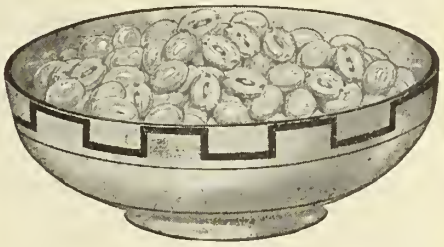
℞

Ovarian Cyst.

C. H. Waters, Omaha (Journal A. M. A., Feb. 2, 1918), says that the attention of a small group of observers has been attracted to the clinical resemblance of certain ovarian conditions to ectopic pregnancy. The most frequent type is that of ovarian pelvic hematocele and subsequent hemorrhage from a corpus luteum cyst. The most important ovarian conditions that may simulate pregnancy are the corpus luteum cyst, the twisting of the pedicle of a cyst, rupture of the cyst with or without hemorrhage, ovarian hemorrhage and hemorrhage into a cyst. Judging from the literature, the last must be rather infrequent. The writer reports a case which was decidedly deceiving, closely resembling extrauterine pregnancy, in which the patient was operated on. The left ovary was transformed into a dark tense cyst, the size of a small apple. The convalescence was rapid and uneventful, and menstruation has been painless and otherwise nor-

(Continued on Page xvii)



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mal since recovery. He reviews the literature on the subject, and comes to the following conclusions: "It should be kept in mind that corpus luteum or follicular cysts of the ovary may be the cause of delayed menstruation, may, further, give rise to pain, and may thus suggest ectopic pregnancy. With the foregoing manifestations, and in the absence of shock or evidence of intraperitoneal hemorrhage, the diagnosis of unruptured tubal pregnancy or of a corpus luteum or follicular cyst of the ovary will often be in doubt. The rational and safe procedure is early exploratory operation."

℞

Epinephrin.

The administration of epinephrin by intraspinal injection in acute or subchronic cases of low blood pressure is the subject of a brief article by John Auer and S. J. Meltzer, New York (Journal A. M. A., Jan. 12, 1918). A very low blood pressure, they say, accompanies dangerous states of disease from any source. The problem of whether the low blood pressure is an essential characteristic of shock is still being discussed, but many physicians agree that any means of raising the blood pressure makes recovery more hopeful. The use of epinephrin has been suggested, even by writers who do not believe in low blood pressure as an essential factor of shock. According to recommendation, it is usually given intravenously, though the rise produced is of short duration and terminates with a fall of blood pressure lasting for some time. At various times the authors have observed and studied the effect of epinephrin on blood pressure when administered by subcutaneous, intravenous or intraspinal injection. So far as animals are concerned, the effect of subcutaneous injection is very small, though it may last longer than that of intravenous and intramuscular methods. The writers refer to some published experiments by themselves on monkeys which showed that intraspinal administration might be more lasting, and

(Continued on Page xviii)

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they have tested the question again in three monkeys with similar general results. They therefore suggest the use of intraspinal injections of epinephrin in cases of low blood pressure under present war conditions. The initial dose should not be less than 3 c.c. of a 1 to 1,000 solution. Without wishing to discuss the favorable results of the treatment in poliomyelitis, they wish to say that when epinephrin was given in doses no smaller than 2 c.c. every few hours, there were no harmful results. A rise in blood pressure was observed whenever it was looked for. In human beings, the injection of epinephrin in the lumbar region is more easily executed and is more uniform and reliable than in monkeys. In experiments with intrapharyngeal insufflation, the writers have learned that a considerable pressure on the abdomen with a board and bandages definitely increases the blood pressure. This has been observed also by previous authors. The writers would advise that, thirty or forty minutes after the intraspinal injection, a subcutaneous injection of the solution should be added, at the same time admitting that this may not be life-saving. They nevertheless hold that any physician should employ any remedy that may contribute to the saving of human life.

———℞———

Functional Kidney Tests.

B. A. Thomas and J. C. Birdsall, Philadelphia (Journal A. M. A., November 24, 1917), report a study of the comparative value of ten of the more commonly employed and reliable kidney tests carried on by them during the last two years. These tests are enumerated as the indigo carmin, phenolsulphonephthalein, the total non-protein of nitrogen of the blood, the urea nitrogen of the blood and urine, urine urea by the sodium hypobromite method (Doremus-Hinds ureometer), Ambard's ureosecretory constant of the blood and urine, the creatinin of the blood, and the cryoscopy of the blood and urine. These were selected from the more extensive list be-

(Continued on Page xxi)

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cause several of them are routine methods and are believed to be the most reliable and practicable. A number of others, such as phlorizin, potassium iodid and lactose, experimental polyuria, acidosis and chlorids, might have been included if they were not either more or less discredited or lacking in universal confirmation. The experimental polyuria test of Albarran has much to recommend it, but serious objections to it ruled it out. The writers give a long description of the technic they used in the various tests and summarize the results of the study as follows: "1. The analysis of the results of the several functional kidney tests employed in this study emphasize our belief that of those utilized none possessed virtues superior to indigo carmin, not excepting the tests of retention. 2. Indigo carmin, in our experience, has been more trustworthy and practical than phenolsulphonephthalein. 3. In cases which may require an additional functional test for confirmatory judgment, phenolsulphonephthalein, total nonprotein nitrogen or urea nitrogen of the blood may be utilized. 4. Ambard's quotient is of questionable utility so far as the differentiation of nephritis is concerned, and possesses no actual advantage over indigo or phenolsulphonephthalein. 5. Cryoscopy of the whole blood and urine is valueless. If unilateral values are desired, ureteral catheterization is necessary and may be obviated by recourse to more modern and practical tests. 6. Creatinin of the blood and urine urea nitrogen, either per hundred c.c. by the urease or by Doremus' sodium hypobromite method, demonstrate results so variable as to be unreliable. 7. Irrespective of the finer medical aspects of renal function, the differentiation of glomerular and tubular nephritis, the detection of renal disease in its incipiency, etc., the best functional kidney test today is indigo carmin, at least for the surgeon, because it is not only the most practical test, but it is unsurpassed in reliability, whether employed for unilateral determination by the method of

(Continued on Page xxiii)

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Venereal Disease in Camps.

J. B. Clark, New York (Journal A.M.A., December 29, 1917), describes a follow-up method for the control of venereal disease among soldiers which has been used in Camp Lee, Va. It consists first in a running record on cards giving an outline of the entire activity of the genito-urinary service at the base hospital; second, a means by which all patients can be observed and their records continued after their discharge; third, and most important, a method of restricting all infected patients from absenting themselves from the reservation, until on examination such patients are found free from infection and may safely be allowed to pass. The forms used are shown in the order of their importance, beginning with the patient's condition on admission and showing the changes that occur in the patient's case as long as he is under observation.

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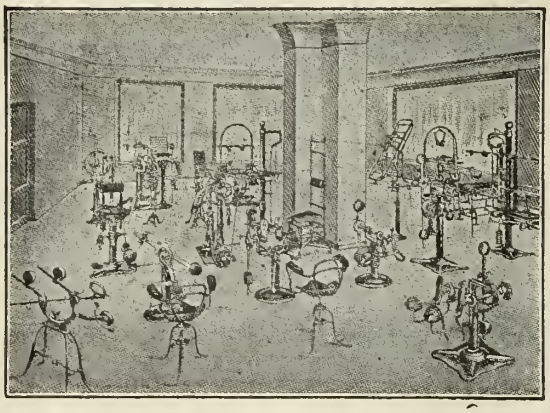

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THE JOURNAL
of The
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Vol. XVIII TOPEKA, KANSAS, MARCH, 1918 No. 3

A Consideration of Chronic Degenerative Myocardial Changes.

FRANK A. CARMICHAEL, M.D., Osawatomie Kansas.

From the Clinics of the Osawatomie State Hospital.

Although most of the observations contained in this paper were fully elaborated some years ago and might be considered as not exactly up to date, an attempt to demonstrate marked advances in either the pathological research or the therapeutic advancement in conditions of cardiac myopathy, particularly of this type, fails to reveail any marked discoveries along this line. The frequent occurrence of death from lesions of the heart in those who have apparently enjoyed robust health and in whom the presence of such disease has been unsuspected, the great diversity of contributing etiologic factors and the too frequent paucity of autopsy findings contribute to excite the interest and prompt a serious study of a type of cardiac disease so frequently latent as to symptoms but so appallingly sudden in the exhibition of its lethal powers.

I am speaking particularly of the type of myocardial degeneration known as myofibrosis, a condition that while recognized as a pathological entity is not amenable in the strictest sense of the word to as clear classification or to the certainty of its etiological factors as are other less common cardiac conditions. Nothing I have encountered in recent literature may be considered as a material aid to a more thorough understanding of the pathology of this condition. While marked advances in the study of pathological conditions involving the endocardium and the pericardium have been made, diseased conditions of the muscle of the heart itself show a lack of that definiteness in outlining its pathology that has been so characteristic in the literature of the past fifteen years.

With the tendency to materialism and the disposition to assign some definite specific cause in the production of all pathological conditions of whatever nature, our attention has been engaged in a consideration of the more interesting study of lesions involving the endocardium because of their more frequent occurrence, the symptomatology they evidence and the diagnostic features that contribute much to the interest of their study. However, it has been observed in many cases that have died suddenly from heart failure that not only has the pathology of the heart muscle varied within wide limits from those conditions exhibiting pronounced fibrotic changes and extensive areas of degeneration, those showing mere fragmentation to those in which both macro and microscopically show no evidence of pathological process sufficient to cause death and in which in fact no definite evidence of diseased condition of the muscle of the heart can be determined. It is these facts and the additional fact that at that period of life when death from heart failure is most common, that we may expect to find certain changes in the heart muscle that are to be considered purely physiologic, coupled with a lack of physical confirmatory symptoms and the frequent latency of this condition that center the attention and invite

the interest of the investigator.

In a majority of cases coming to autopsy following sudden death from myocardial disease of the chronic type, degenerative arterial changes are present. In fact, it may be said that endarteritis, atheroma and arterio sclerotic changes both diffuse and nodular accompany myocardial disease with such frequency as to be almost looked upon as an integral part of the general process. But in controversion of this, the number of cases in which these conditions are not present is not inconsiderable and the rather advanced age in a majority of these cases would favor arterial changes as above noted.

As to the nature of the myocardial change itself the opinions of pathologists are at variance. It would seem, however, that a consensus of these regard the term myocarditis as used in a general sense a misnomer. Inasmuch as evidences of an inflammatory process per se are usually wanting, the condition is to be regarded as purely degenerative, neither conservative or productive except from a relative standpoint and is in all probability initiated by an ischemia of the heart musculature primarily due to arteritis of the coronary vessels. It is the tendency of any tissue deprived of its normal blood supply to degenerate, which condition in the heart must result in impaired dynamic efficiency as its musculature is never permitted to rest or relax, and being always in a state of tonus, degenerations with their concomitant impairment of function naturally result in a dilatation resembling primarily physiologic relaxation of the muscles.

The conservative forces of nature, therefore, having determined that the blood supply is insufficient to nourish the heart as a purely muscular organ, are forced to permit certain degenerative or metaplastic changes whereby certain groups of muscle fiber undergo sclerotic changes and are supplanted by a type of tissue that is nonparticipating in the vital functions, requiring a minimum of nutritional supply, thus evidencing an effort on the part of nature to reduce the amount of muscular tissue to that which may have an efficient or sufficient blood supply.

While in these cases of dilatation the heart exhibits an increase in size, macroscopically, there is a relative diminution in dynamic force or in actual contractile muscular tissue. Endarteritic processes in the coronary arteries are usually subacute or chronic in character resulting in gradual narrowing of this vessel. This is most commonly manifested in the anterior coronary artery as a slow obliterative process in the trunk of the vessel or by occlusion of its opening by atheromatous plaques in the aorta, or its manifestation may be sudden and fatal from embolism or thrombosis occurring in a narrow vessel and favored by a sluggish current or a heightened blood pressure caused by diminished caliber of the vessel or unusual exertion. The anterior coronary artery being longer, smaller and more tortuous as well as more active than the posterior, is most frequently involved.

The parts indirectly supplied by this vessel, that is the left ventricle, interventricular septum and papillary muscles show the greatest and most constant pathologic changes. In cases exhibiting more acute coronary obstruction, the condition which Zeigler has described under the term myomalacia cordis occurs. In this condition the heart becomes rapidly ischemic, pale yellow in color and irregular areas exhibiting necrotic changes occur as elevated and softened prominences, the degeneration of the muscle fiber is rapid and marked, they become fragmented and nuclei disappear coincident with sudden and alarming symptoms of dilatation and insufficiency. Sudden death is the rule in these cases, but occasional recovery is recorded where the necrosed area is replaced by a tissue resembling connective tissue in that it bears a close resemblance to the terminal product of an inflammatory process but which must be regarded as a sclerosis or dystrophy, as the evidence of inflammation is wanting. The occurrence of a true chronic myocarditis following acute inflammation of either the pericardium or endocardium, primarly

due to toxemia or acute infection, may be conceded. Whether acute myocarditis itself is due to the direct action of toxins on the heart muscle or to acute arteritis, as held by the French schools, is still a point in controversy, but reliable investigators have found that a myocarditis may occur from uncomplicated valvular lesions in which the compensation has been disturbed and in which the lesion has been attributed solely to dilatation. We may accept the theory of Dehio that myofibrosis is a result of dilatation and is purely mechanical in its response to a dilatation resulting in a lengthening of the blood channels together with a mechanical lessening of their caliber.

As to causes that may be considered operative in the production of compensatory failure there is a wide variance of opinions and not a little uncertainty. By some it is considered that the fibrous deposits are the direct result of old infarcts from disturbance of myocardial circulation. Others have attributed the failure of compensation to deposits of connective tissue between muscle fiber which not only weakens the muscular structure but mechanically embarrasses the contractile power of the heart. This, however, cannot be accepted as a cause, from the fact that true connective tissue is not found in these conditions. This latter view has been so repeatedly contradicted by the results of autopsy findings that it may hardly be given credence.

If we are to accept the theory of the myogenic origin of the heart's activities—that is, that impulses governing its synchronous action originate in the bundle of His—the mechanism of sudden cardiac failure might hypothetically be ascribed as due to invasion of this partical area by sclerotic processes with coincident interference with the conductivity of motor impulses resulting in the dreaded asystole. The analogy of the pathogenesis of myofibrosis with the Stokes-Adams syndrome holds good, even from the viewpoint of those who contend that the latter phenomena is due to sclerosis of the vessels of the bulb. For instance, age, sex and manner of life from an etiological standpoint, the cardiac and arterial degeneration with special reference to involvement of the intraventricular septum which contains in part the bundle of His, from a pathological, the suddenness of the attack preceded by pallor, muscular relaxation, syncope and almost complete cessation of the heart's action, typifying in symptomatology the mechanism of death from sudden cardiac failure from a symptomatic, are truly striking. Only in the one consciousness does not return and the contractile impulse too long delayed is irretrievably suspended. The heart's action is immediately and permanently arrested. While in the other its function is but temporarily inhibited and is resumed after a short interval, though its rhythm is disturbed, resulting in pronounced bradycardia and auricular fibrillation. As the first attack of angina pectoris may terminate fatally, or if not, is regarded merely as a symptom of myocarditis, so the primary shock of heart block to the cardiac innervation may result in sudden death, or if recovery occurs, may be regarded more as a symptom of myocardial change than as a definite pathologic entity. In view of the fact that our present knowledge of the mechanism of sudden death in myocardial degenerations without rupture is practically nil, this conclusion tentatively reached appears tenable.

A study of the symptoms of this condition is of vital interest inasmuch as early regulation of the patient's life and habits may result in warding off for a time at least sudden fatality. The patient is handicapped by the fact that so many cases are latent and are never even suspected until some sudden strain or excitement results in failure and death.

On the other hand cases that come under observation are usually merely characterized by symptoms of chronic cardiac insufficiency without, as a rule, defined symptoms pointing to involvement of the myocardia. The symptoms directly referable to the heart are feelings of precordial oppression or dull pain, frequently with

true anginal attacks, disturbances of compensation resulting in breathlessness on slight exertion, slight cyanosis due to interference with the pulmonary circulation, bronchitis, hydrothorax, dyspnœa, orthopnœa, frequently of nocturnal type, with the addition in more severe cases of pulmonary edema. Almost invariably when the more severe symptoms are in evidence there are added a train of marked digestive disturbances. Embolism and infarctions are common only in mixed lesions. Perhaps the most unsatisfactory feature in the consideration of this condition is the clinician's absolute inability to diagnose the condition during life, as the symptoms are vague and inconclusive and those of fatty heart, pericardial adhesions, hydropericardium and occasional valvular stenotic lesions simulate it so closely as to permit only a tentative diagnosis. Those conditions which may be said to favor a diagnosis of chronic myocardial change are in the order of their importance:

(*a*) Arterio sclerosis wherever found if accompanied by symptoms referable to the heart in the absence of phenomena pointing definitely to endocardial involvement.

(*b*) Dyspnœa and evidence of pulmonary stasis if unaccompanied by murmurs that can be positively identified as valvular (though murmurs due to relative mitral or aortic leakage may be present from dilation and require close study before they may be definitely excluded).

(*c*) The relative strength of the aortic and pulmonic second sounds. These sounds are the most constant in their alteration and may really be considered of value from a differential standpoint. While the heart tones are modified not alone by incidental murmurs due to dilatation and relative valvular insufficiency, but also by alteration in blood pressure and disturbances of proper co-ordination of the heart muscle, though in some cases the heart tones may be clear throughout, and are usually so in the inception of the process. Faintness in the aortic and accentuation of the second pulmonic have been noted with such constancy as to be regarded as characteristic of this type of lesion.

(*d*) The blood pressure from a diagnostic standpoint is dependent entirely on the state of compensation present, but is usually high because of coincident arterial involvement.

(*e*) The variability of the pulse makes it of slight value in determining the character of the lesion. In many cases there is arrhythmia either continuous or intermittent in type. Persistent bradycardia may be observed throughout and when accompanied by syncopal attacks, is highly suggestive, though not conclusive. In many cases a regular pulse may be present, while rapidity prevails in a majority of cases.

A contemplation of our present methods of treatment is by no means satisfactory, and there seems to be no direct treatment of the established conditions. Whatever therapeutic effort has been expended seems to have been directed toward the correction of the most commonly ascribed casual factor; i.e., arterial change. As stated in reviewing the pathology of this condition, arterio schelosis, while a frequent accompaniment of myocarditis, is my no means always demonstrable, nor is it except with reference to the coronary arteries essential, nor does its demonstrable presence in peripheral vessels determine that myocardial disease exists. This uncertainty with the fact that the iodides which seem even yet to constitute the mainstay of treatment of this condition when administered for long periods and in proper doses, has utterly failed to produce any favorable change in the arterial condition in many cases, but on the other hand as frequently augmenting the distressing gastric symptoms so often present would lead us to suspect its employment as empiric rather than rational.

Digitalis, one of the most dependable as well as the most abused drug in our armamentarium, is of doubtful value. Some urge its use in the so-called early stages, though we are not able to diagnose the condition in its early stages nor with absolute certainty in any stage. Nearly all concur in the opinion that its employment

in advanced myocardial change is contraindicated and obviously so if bradycardia and high arterial tension are present. Some authors have advocated its administration in combination with nitrates, though to the writer it seems there is no justification for the employment of these.

It has been shown by McKenzie that its (digitalis') action is that of a universal depressant of all the heart functions, and that this action and effect is due to the fact that it is a direct muscle poison. The proof of this assertion has been very convincingly set forth by Duroziez and is fully confirmed by Goepp. It would seem that the administration of such a drug with its well known toxic action and cumulative tendencies would be hazardous if continued for long periods. On the other hand the almost constantly increased blood pressure existing in these cases would indicate the exhibition of the nitrates for long periods and increasing doses if tolerance seems to be established, combined with physical and mental rest, and such dietary and hygienic measures as will contribute to the physiologic rest of the overworked heart. Under this treatment alone the dilatation, which may be considered a primary and very probable predisposing factor in the production of tissue changes in the myocardium, may be combated.

In the treatment of this condition, as in the others of obscure pathology, some very fantastic methods have been exploited. This is strongly evidenced by Heitz in the revival of the carbonic acid bath in the treatment of these cases. This method of treatment might exert an evanescent effect on the size of the heart, when dilatation is not extreme or where there is no element of hypertrophy. The probability of permanent benefit is extremely slight and even if pronounced benefit were to accrue from its employment, the difficulty of its practical application precludes its common employment. It is claimed for the Nauheim treatment that it lessens the area of cardiac dullness, slows and strengthens the pulse and respiration and relieves local pulmonary congestion, enlargement of the liver and other organs (all of which may be achieved by the simple warm bath). On the other hand it states the general arterial pressure is raised and the skin and peripheral circulation stimulated. But passing reference is necessary to the strengthening exercises of Schott. This lacks the correctness of applied scientific principle because the strength and recuperative capacity of a given heart are unknown quantities and even after apparent progressive improvement for a time the heart may rapidly fail, or sudden death supervene without warning. Again the method is not available for the general practitioner, as it may be successfully employed only under the direct supervision of a physician whose judgment has been matured by special experience in its administration.

A word in condemnation of the indiscriminate use of cardiants seems timely. We realize that it is fully as logical to apply the whip to an overworked and exhausted horse without lightening his burden as to attempt to relieve an overworked heart by any drug calculated to stimulate its action, except, perhaps, to tide over a very brief crisis. The employment of drugs to strengthen the heart's contractile force results only in increased blood pressure and an increased expenditure of cardiac energy. What the overladen animal requires is lightening of its burden and proper rest. What the weakened and overtaxed cardiac muscle requires is the same. There is no difference in principle.

At first glance the administration of depressants as aconite and veratrin in weakness and irritability of the cardiac muscle would seem to invite disaster. Yet in many of these cases showing progressive failure of the heart muscle with irritability, small doses of these frequently result in the amelioration of symptoms that would be augmented by the use of cardiac stimulants. The prognosis is usually unfavorable, uncompromisingly so as to ultimate recovery, though regulation of habits and manner of life may prolong existence. It may be said that the prognosis is rela-

tively more favorable in elderly than in youthful patients, partly because the habits of the former are more quiet and the heart is able to meet the demands of the condition of physical decadence. In youthful subjects it is less able to meet the requirements of a vigorous body with the frequent sudden muscular demands made upon it. Added to the prognosis of uncompensated valvular lesions the extra hazard of deteriorated heart muscle and the numerous conditions that attend it such as angina pectoris, heart rupture, cerebral anemia or coronary occlusion must be considered. The most trifling intercurrent affections may prove fatal. In my experience those cases exhibiting marked gastric irritability pursue a rapid and uniformly fatal trend.

Carefully reviewing the entire subject in the light of our present knowledge the following conclusions in brief suggest themselves:

First: While in many diseases age, sex, habit and mode of life may be regarded as possible etiologic factors in the production of disease of the myocardium of fibroid or fibrotic type, they are not constant. Age, sex, etc., should not be considered etiologically, as its occurrence independent of any determinable predisposing cause is so frequent as to show conclusively that its origin may be independent of such factors.

Second: That the mechanism of these changes in the heart muscle has not been clearly defined, but it is more or less a theory requiring closer observation and more thorough study as to their method of production.

Third: That arterio sclerosis of the peripheral trunks in heart lesions may not be accepted as even presumptive evidence of disease of the myocardium except in such cases as admit of absolute exclusion of endocardial implication and even in such its existence may be considered as only of presumptive value.

Fourth: The mechanism of sudden death in these cases exclusive of rupture must be due to sudden and absolute inhibition of contractile impulse resulting in asystole and that its manifestations exhibit so close an analogy to those of the Stokes-Adams syndrome as to permit a reasonable assumption that the same pathologic process governs both phenomena, which assumption is so far sustained by the similarity in pathological findings.

Fifth: The fibrotic changes may be considered as a result of a cycle of three events:

(*a*) Sclerosis of the coronary arteries resulting in deficient blood supply.

(*b*) Dilatation following, and the direct result, of anemia dependent on the above.

(*c*) Fibrotic changes due in part to primary coronary arteritis and in part to the dilatation which lengthens the course and diminishes the caliber of the cardiac vessels.

Sixth: That fibrotic changes when once established are permanent with a tendency towards slow progression, are uninfluenced so far as known by any method of therapy, but under proper hygienic conditions in their earlier stages are amenable to arrest of progressive tendencies.

Seventh: That symptoms when present are vague and may be applicable to so many other cardiac derangements as to afford merely presumptive grounds for a diagnosis.

Eighth: That the use of all cardiants in general and digitalis in particular, that stimulate the contractile power of the heart muscle without lessening the peripheral resistance are ill advised and irrational and tend rather to favor than to arrest the progress of the lesion.

Ninth: That opium as advocated by Musser is one of the most valuable remedies at our disposal in cases where the condition of disturbed compensation gives rise to nervousness and apprehension, acting as a tonic to the heart, reducing peripheral resistance, quieting nervous tendency, steadying respiration, allaying dyspnœa and giving necessary mental and physical rest.

Tenth: In view of the favorable reports from the use of cardiac depressants in

selected cases the cautious exhibition of such drugs as aconite and veratrin are justified if administered in small doses and the effect closely watched, as there are undoubtedly cases that experience distinct benefit from their administration.

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Trachoma.

DR. F. L. MCDANIEL, U.S.N.S.

Read before Miami County Medical Society, February, 1917.

In selecting this subject the writer was influenced by the fact that during one year spent as Medical Officer in the U. S. Indian Service he personally treated, over periods varying from one to six months, two hundred individual cases of trachoma and during the same time examined and diagnosed over three hundred additional cases which he was unable to treat on account of the long distances these cases lived from the hospital and dispensary.

From time immemorial, trachoma has existed in Europe as an endemic disease. However, it was only at the beginning of the last century that this disease began to attract the attention of physicians. It was thought that it was introduced into Europe from Egypt by the armies of Napoleon I and was called ophthalmia Egyptiaca. Trachoma spreads rapidly when introduced among a primitive race of people living under poor sanitary conditions and we find that not less than 80 per cent of our American Indian population has or has had trachoma. It is on this account that the disease is of vital interest to the practitioner in this country, as it is a fact that although trachoma is regarded as a rare disease among the whites of the United States, its apparent rarity is due more to the failure to recognize the condition when met than a real absence of the disease.

Trachoma or conjunctivitis trachomatosa is an inflammation of the conjunctiva which originates by infection and produces an infectious purulent discharge.

The disease is undoubtedly due to a microorganism, but as yet this organism has not been definitely isolated. However, Hans Herzog claims to have found, encapsulated in the epithelial cells and leucocytes, what he calls "involution" derivatives of gram-negative diplococci. The disease is disseminated by means of contact, mediate or immediate, such as by common towels, bed linen, etc., which has been contaminated by the infectious secretion. Hence we find the disease mainly attacking the poorer classes who live crowded together and bestow little care upon cleanliness.

The early stage of the disease is characterized by pain, lachrymation, sensitiveness to light. The conjunctiva, especially of the tarsus, becomes reddened and thickened, with an hypertrophy of the mucous membrane. This hypertrophy of the conjunctiva is the most prominent characteristic of the disease and occurs in two forms, the papillary and the granular. Sometimes these two forms occur separately, but both are usually found present in the same eye at the same time. The papillary form consists in the development of the so-called papillæ which appear as newly-formed elevations on the surface of the conjunctiva, which gives it a velvety appearance. It is most clearly pronounced on the upper lid, which must always be elevated in making a diagnosis of trachoma.

The granular form is distinguished by the presence of trachoma granules. They appear as gray, translucent, roundish granules which push up through the superficial layers of conjunctiva forming hemispherical swellings. On account of their gelatinous character they look very much like frog spawn eggs, or boiled sago. They are found principally in the fornix. When the lower lid is pulled well down sometimes these granules may be seen arranged in rows presenting the appearance of a string of pearls. The conjunctiva of the eyeball shows a coarsely reticulate injection. The secretion from the eyes at this time is very thick and purulent and highly infectious.

If the disease is untreated it tends to run an acute course of from three to six months and develops into the chronic form. The hypertrophy of the conjunctiva which has been very marked begins to recede with

signs of cicatricial contraction. Fine cicatricial bands forming narrow whitish striæ appear on the conjunctiva of the tarsus and grow in size until the tarsal conjunctica appears pale, thin and smooth. There usually develops disturbances of sight caused by ulcerations of the cornea and also by pannus trachomatosus produced by a deposition of newly formed gelatinous, vascular tissue on the cornea. In old chronic cases many times upon trying to evert the lids, especially the upper, it will be found impossible to do so on account of numerous fine fibrous bands extending from the conjunctiva of the eyeball to the tarsal conjunctiva, producing an anterior symblepheron.

The principal cause of blindness resulting from this disease is the development of a keratitis giving rise to a ground-glass cornea.

As mentioned before this disease tends to run an acute course of several months duration and then gradually subside into the chronic form which may last a lifetime with development of the various sequellæ. The discharge which is so profuse and purulent in the early stages becomes scanty and serous in the chronic form so that the eyes feel dry and rough. Occasionally the disease begins so early in life or so insidiously that we run across individuals with typical chronic trachoma who cannot recall having had an acute attack.

We now come to the methods employed in the treatment of trachoma and, although this disease can be cured in the early stages, and greatly improved even in its chronic form, it requires an inexhaustible amount of patience and perseverance on the part of both the physician and patient to get successful results. The patient must be seen and treated every day by the physician and when it is remembered that this must be continued sometimes for many months it is easily understood why so many cases of trachoma go untreated and run a chronic course. The most successful methods of treating this disease consist in a combination of medicinal applications together with use of mechanical or surgical measures.

The writer's method of treating trachoma is briefly as follows: In acute cases the eyes are irrigated several times a day for two or three days with weak solution of boracic acid. The patient wears dark glasses and otherwise protects the eyes from light. On the third or fourth day, by means of a Knapp's trachoma forceps the granules are forcibly expressed. This is done thoroughly, even rigorously, as the scarification produced is beneficial and by development of cicatrix reduces the hypertrophy. The eyes are then irrigated with boracic solution and a few drops of 10 per cent aqueous solution of argyrol instilled in each eye. This is not washed out. The argyrol treatment alone is continued for two or three weeks, occasionally rubbing the everted lids rather vigorously with gauze. After two or three weeks the argyrol treatment is only given every other day and on the alternate days a few drops of an aqueous solution of copper sulphate in glycerine, which is prepared by diluting a 10 per cent copper sulphate solution in glycerine with 15 to 60 parts of water. Also at intervals the hypertrophied conjunctiva is gently massaged with a pencil of copper sulphate crystal. Following this line of treatment the writer has obtained practically 10 per cent of recoveries in acute cases where the treatment was continued until every vestige of hypertrophy has disappeared, and this may take many months. If treatment is not continued until the hypertrophy has disappeared and conjunctiva returned to as near normal as possible, a relapse is almost certain.

The treatment of the chronic form is very discouraging and the best we can hope for is an amelioration of the condition and prevention of the serious sequellæ. In this form the writer usually gives the patient a 10 per cent copper citrate ointment with instructions to rub well into the eyes, preferably at bed time. A warm boracic acid douche is used in the eyes in the morning and the patient ordered to report to the physician at regular intervals for observation. Areas of hypertrophied conjunctiva

still remaining are occasionally touched up with a copper sulphate pencil.

In addition to the above specific treatment, the general hygienic conditions of the patient should be improved and strict precautions observed to prevent the spread of the disease. In the various United States Indian schools of the country the pupils are strictly prohibited from using any but their own toilet articles, etc., and the Pullman system of towels is used, and each pupil sleeps in a single bed.

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Toxemias of Pregnancy.

E. G. Coyle, M.D., Coffeyville, Kansas.

Read before the Montgomery County Medical Society, November, 1917.

Toxemia of pregnancy is a condition with which you have, in all probability, had occasion to deal with more or less frequently, and it is a condition which occasionally, as one of my colleagues expresses it, tends to make the icicles drop off the end of your nose. I refer to the toxemias of the latter half of pregnancy, which so frequently have as their climax an eclamptic seizure.

Since the discovery of albuminuria preceding and accompanying eclampsia, kidney insufficiency has been regarded as its chief cause. Recent studies, while not diminishing the importance of imperfect elimination, have established other factors in the causation of the disease. These theories start with the common assumption that the fœtus or ovum is the source of toxins contaminating the maternal blood. Kodman points out that the fibrin forming elements of the blood are much increased in eclampsia. To these globulins which furnish an excess of fibrin is ascribed the toxicity of the maternal blood. Experimentally the substances have been demonstrated capable of producing eclamptic symptoms.

Whether these substances are derived from the syncytium of the placenta or from fœtal metabolism is a disputed point, although the majority contend that the toxins are derived from fœtal metabolism for the following reasons: The toxemia of the first half of pregnancy causing vomiting, etc., is probably due to the syncytial growth and is not affected by eliminative treatment or diuretic management to spare the work of the liver and kidneys, while such treatment favorably affects the toxemia of the latter half of pregnancy. The symptoms of the latter half of pregnancy usually disappear with the death of the fœtus. In hydatidiform mole, where there is an enormous overgrowth of syncytium, eclampsia is extremely rare. The toxins of the maternal blood are conveyed to the liver where they are converted into substances fit for elimination by the kidneys. If the liver fails in this function or breaks down under the strain imposed upon it, the maternal blood contains toxic material irritating to the kidneys, the central nervous system and capillaries everywhere. The kidneys manifest the irritation of their capillaries and epithelium by symptoms of a parenchymatous nephritis, namely the appearance in the urine of albumin, casts and blood cells, also a diminution of the total quantity of urine excreted.

Eclampsia occurs about once in three hundred cases of pregnancy, most frequently during labor, next in pregnancy, and least frequently in the puerperium. Most of you will, I think, admit that when you hear of a case of eclampsia the first thought that runs through your mind is that the doctor in charge has failed to examine the urine as often as he should. While that thought is justifiable in the great majority of cases, as we have seen from the above discussion of the causes and premonitory clinical symptoms of eclampsia—I refer especially to the albuminuria—there are a number of cases in which there is no albuminuria before there have been one or two eclamptic convulsions; and, as Brach has shown, albuminuria is rather a constant finding after muscular exertion, having found the typical picture of parenchymatous nephritis in nineteen out of twenty-four contestants after a marathon race. The albuminuria that appears after an eclamptic seizure may be due to the muscular exertion dur-

ing the convulsion. Some of the cases I have seen tend to confirm this opinion, three of five cases showing albuminuria only after eclamptic seizure, the other two cases, which I will cite first, conforming more closely to the text-book picture.

Case No. 1.—Patient about thirty-six years old, fifth pregnancy, syphilitic. Urine showed albumin about the seventh month, no history of kidney trouble in former pregnancies. She was put on a diet, given a diuretic and instructed to bring in a specimen of urine regularly. She only brought in one other specimen of urine during the remainder of her pregnancy, which also showed albumin and casts. The amount of albumin was not sufficient to be alarming, especially since she was feeling so well. Labor came on at term, lasted about four hours, child seemingly in good condition, mother talked rational and felt well after delivery. About two hours after delivery patient had typical eclamptic seizure. She was given an enema, croton oil four drops, in an hour seven drops, and again in an hour seven drops. The first bowel movement occurred about three hours after the first convulsion, during which time the convulsions occurred about every twenty minutes. After the first bowel movement there were no more convulsions and the patient made an uneventful recovery, although she never remembered anything about the confinement.

Case No. 2.—Primipara, age twenty, history negative. Examination of urine at seventh month showed no albumin. About three weeks later patient came to the office complaining that her ankles were swelling badly. Examination of urine showed a marked amount of albumin. She was put to bed, diet restricted to milk, diuretics given, free catharsis and sweat baths, and she was encouraged to drink a good deal of water. The first twenty-four hours in bed she passed about a half cup of urine containing about 70 per cent albumin with blood cells and casts. The sp. gr. was 1024. The next twenty-four hours she passed a cup of urine, or 250 c.c., the next twenty-four hours 500 c.c., sp.gr. 1022, albumin about 50 per cent, blood cells and casts. For the next four days there was no increase or change in the urine, the edema increasing all the time, slight headache, no disturbance of vision. Labor was induced on the seventh day, lasted about twelve hours. There were no symptoms of eclampsia on the part of the mother. The baby, a strong eight-months baby weighing four and three-fourths pounds, was apparently healthy. Two hours after birth the baby developed a typical eclamptic convulsion and died during the convulsion. The mother passed about 1000 c.c. of urine during the first twenty-four hours after the birth of the child, showing a large amount of albumin. The secretion of urine increased and the amount of albumin decreased until the fourth day, when the albumin entirely disappeared. The edema gradually subsided and was entirely gone at the end of ten days.

Case No. 3.—Primipara, age nineteen. History negative, a normal healthy woman. Monthly examinations of the urine were negative. About the eighth month I examined this patient to ascertain the position of the baby and her condition generally. At that time there was no edema except around the ankles, which she said was only present in the evening after she had been on her feet all day. The reflexes were very active. I had them bring in a specimen of urine about every week from the date of this examination. The patient was due to be confined about the third of January. On the thirty-first of December the husband was in the office and said his wife was vomiting quite frequently. Requested that he bring in a sample of urine, as it had been ten days since I last examined it. That evening at supper she complained of slight headache and laid down. About thirty minutes later she had an eclamptic convulsion. She was immediately taken to the hospital, where examination showed the cervix not dilated. Urine per catheter showed albumin. The patient did not regain consciousness after the second convulsion. Convulsions occurred about every ten minutes. It was

decided that a cesarean section should be performed and this was done. The patient went through the operation nicely, the baby was alive and has never shown any signs of kidney insufficiency. After the operation the patient was only semiconscious for the next twenty-four hours, the kidneys only excreted about 500 c.c. of urine and we could not get any action from the bowels on account of persistent vomiting. About thirty hours after the operation the patient had another eclamptic convulsion. We then resorted to venesection, removing about 500 c.c. of blood, washed out the stomach and gave about two ounces of a saturated solution of magnesium sulphate. The bowels acted in about three hours. There were no more convulsions and the next day there was absolutely no albumin in the urine.

Case No. 4. — Primipara, age twenty-eight. Previous history—ectopic pregnancy operated one year before, uneventful recovery. Urine showed no albumin before labor, which was normal. Puerperium uneventful until the eighth day when she had an eclamptic seizure. Venesection was used in this case. The patient had only six or seven convulsions, and while the urine showed considerable albumin after the first convulsion it was completely normal again in two days.

Case No. 5.—Primipara, age seventeen, had been in labor about twelve hours, cervix fully dilated and head engaged when she had an eclamptic convulsion. The urine had been examined the day before and showed no albumin. She had six convulsions before the baby was delivered with forceps. A catheterized specimen immediately after delivery showed only a trace of albumin. A catheterized specimen twenty-four hours after delivery showed no albumin.

The conclusion I draw from the above cases is that the examination of urine of pregnant women is a very important procedure, in the latter half of pregnancy especially, for when albuminuria is detected and the proper treatment instituted, a great many cases of eclampsia are aborted. In the series of cases I have cited, Case No. 2 would have undoubtedly developed eclampsia if allowed to go to term. In the cases which show no albuminuria there is, so far as I know, no premonitory sign which would warn the physician of the impending danger.

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Need for Patent Law Revision.

The Council on Pharmacy and Chemistry publishes a report prepared by its committee on patent law revision, which is an appeal for an amendment of the patent law which governs the issuance of patents on medicinal preparations, and more particularly for a revision on the procedure under which such patents are issued. The report points out that to increase our national afficiency, the government must protect and stimulate science, are and industry, and at the same time curb waste of the country's resources; and that, to this end, the patent office should encourage discoveries which go to increase national efficiency, and refuse patent protection when such protection is not in the interest of national efficiency, conservation of energy and material resources. The report presents a considerable number of specific instances which demonstrate that patent protection has been given where it was not deserved and not in the interest of the public. The report concludes with a reference to the investigation of a patent granted for a preparation of secretin, apparently without any attempt to confirm the highly improbable claims of the patent applicant. (Jour. A. M. A., Jan. 12, 1918, p. 118.)

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Acetylsalicylic Acid and Phenyl Salicylate Incompatible with Alkalies.

In the presence of moisture, acetylsalicylic acid is decomposed by magnesium oxide (calcined magnesia), as is also phenyl salicylate (salol). Hence these drugs should not be combined with magnesium oxide in a prescription. (Jour. A. M. A., Feb. 9, 1918, p. 410.)

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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The State Meeting.

The annual meeting of the Kansas Medical Society will be held in Kansas City on Wednesday, Thursday and Friday, May 1, 2 and 3. According to the custom established at the Topeka meeting in 1916, one full day—Thursday—will be set aside for papers and addresses by men of prominence from other states. The Kansas City fellows promise you plenty of entertainment.

In spite of war conditions, in spite of your heavy work, you should arrange to attend this meeting. There has never been a time in its history when the Society needed your personal interest more than it does now. A great many of the men who have been active in Society affairs are now in active service with the army. This makes it particularly important that you should become more than usually active in medical society work.

We realize how many affairs there are to absorb the time and attention of our members, but we must not neglect our organization. There are many reasons why our societies should be kept intact and made larger and stronger than ever. There is already need for co-ordinate action by the medical profession and there will be much greater need as the war progresses.

Every member of the Society, who is not in the army service and unable to get a leave of absence, or who is not too old and too feble to travel, should attend this meeting at Kansas City. We know most of you are very busy, but it might do your patients a lot of good if you would leave them for a couple of days to attend this meeting. You have been having such long hours and such worrysome work that you are absolutely cross and grouchy. Your wife has told you so and your patients have commented on it. Attend this meeting at Kansas City, get two or three days rest and recreation and, perhaps, some new ideas; and go back to your patients with a smile on your face, cheer in your eyes and hope in your heart. It will do you good and it will do them good. Their confidence in you will be renewed and they will respond more promptly to your treatment.

Remember the dates. Remember the place.

THE PROGRAM.

Arrangements are already being made for the speakers for Thursday and an excellent program for this day is promised.

There will be plenty of time on Wednesday and Friday for a good many papers and case reports. You can write an excellent paper if you will try, even though you are busy, if you spend a few minutes every day getting the data together, and then an hour or two in arranging them. Give us a paper along some line of your work so that it will be instructive to us and beneficial to you. Send the subject to the Secretary as soon as possible. Do not wait for a personal invitation. You are all invited to take part in the program.

Help Put the Owen Bill Through.

It is a matter of considerable importance to every member of the medical profession that those who have so readily given their services to the great cause of liberty should be given credit for the work they have done and will continue to do, and that they should not be held responsible for conditions for which they are in no way re-

sponsible and are powerless to remedy.

The newspapers have given wide publicity to the very unfortunate conditions which existed in some of the cantonment hospitals a few months since, and they have permitted the public to understand, without definitely saying so, that the medical officers were to blame, that they were negligent in their duty and careless and inhuman in their attention to the sick.

It seems that the only way the medical department may be able to do its full duty to the army and be *justly* held responsible for failure to do so, is to give such rank to its officers as will command respect from line officers, and give them authority to give orders instead of recommendations in all matters which concern the health of the army.

The Owen bill now before Congress is expected to remedy the difficulties which now exist. Every physician in the state who appreciates the present situation and has the interests of the medical profession at heart should write to his congressman and senator, urging them to support the Owen bill. We reprint from the Journal of the American Medical Association, March 2, two editorials bearing upon this subject, and trust that you will give them careful consideration:

INCREASED RANK AND AUTHORITY FOR MEDICAL OFFICERS.

The time has come to make a final effort to impress on Congress the importance of an early and favorable consideration of the Owen and Dyer bills. It is not necessary to recapitulate the fundamental arguments that call for congressional approval of this legislation. However, we must here emphasize that the success of this measure is desired primarily in the interest of the sanitary and health conditions of the Army.

The sanitary service of troops is not an imposition or a necessary evil, as Colonel Ford has pointed out in the introduction to his work on military hygiene and sanitation, but an effort to assist the commander in preserving the health, and thus the number and morale of his troops. It is an essential and integral part of the military organization. If the sanitary service is to operate to its full efficiency, its advice must be consulted and its orders must be obeyed. "Discipline is essential for the proper enforcement of orders affecting health," says Colonel Ford. "The sanitary adviser can do nothing if his recommendations are not enforced by the commanding officer. Under similar circumstances the morbidity of those commands whose discipline is lax, is invariably higher than is that of those whose discipline is strict. . . . In the last analysis, however, responsibility for the health of the command rests upon its commanding officer."

Although it is true that the health of the troops under the administration of our Army today is an indication of the judgment and experience of the commanding officer, the fact remains that if epidemics arise, if there occurs an increased morbidity and mortality among the troops, if anything even remotely affecting the good health of the troops receives publicity, the Medical Department is called to account. The public does not criticize the commanding general of the War Department as a whole; it is the Medical Department which receives the blame and which must appear before the bar of public opinion to justify its work and its ability. Every one knows that the primary purpose of the Army is military efficiency, and that important as are hygiene and sanitation, they must sometimes be ignored. As Ford says, "Military exigencies must dominate before an engagement, during it and perhaps after it." But when troops are in camp and undergoing training over long periods of time, as are our troops at present, the medical and sanitary officer should not be in the position of a mere adviser of little rank whose recommendations may be considered by a line officer as the latter's judgment or disposition may indicate. The medical officer should be given rank sufficient to command the wholesome respect and consideration of line officers, and with this rank should be authority to enforce an important order without bias against his future Army life.

PETITION CONGRESS.

No arguments should be necessary to convince civilitn physicians of the necessity for the success of some such legislation as that provided by the Owen and Dyer bills for increased rank and authority of medical officers. It should be remembered, however, that Congress, which usually is busy in time of peace, is even more pressed with work in time of war, and however anxious the individual congressman and senator may be to inform

himself completely on each measure before casting a vote, the demands on his time are such that frequently this is impossible. There has arisen, therefore, the method of influencing Congress by a direct appeal from the citizens of the country to their representatives. In view of this fact, the American Medical Association last week sent to every county society in the country an appeal to take up this matter individually and collectively, and to petition the senators representing their state and the congressman representing their county to support this measure. An organized appeal of this character, backed by the request of the physicians of the country and supported in turn by the citizens with whom physicians may have influence, will cause Congress to give these appeals the special consideration which they merit.

Eliminating the Unfit.

Up to February 23 there have been 1,050 officers of the Medical Reserve Corps discharged for various causes and thirty-one have died. According to the classification of discharges published, 411 were discharged on account of physical disability, 154 for inaptitude for the service, 306 were discharged in order that they might join other branches of the service, domestic difficulties caused the discharge of 59, because they were needed by communities, hospitals or schools 32 were discharged, and 88 resignations were accepted.

Altogether 21,740 have been accepted and recommended for commission and of this number 13,687 were on active duty February 23. About 4,000 applicants were rejected. At the present time the discharge of medical officers averages about fifty a week.

At first one may be inclined to criticize the laxity of the examining boards that passed these men for commissions, but, after considering the situation at the beginning of the war and the immediate need for the services of a large number of medical officers, one must admit that the recruiting plan was probably the best that could be devised. Perhaps more care in the physical examination of applicants for commission would have been advisable, and no doubt would have been observed had the boards realized the severe physical training these men would be given. We quote from the Official Bulletin, February 26, the following in regard to the recruiting plan and the methods used for eliminating the unfit:

"All the physicians and surgeons taken into the Medical Reserve Corps to care for the new armies were chosen by the following plan:

"1. All candidates were required to be certified by the American Medical Association as being reputable and in good standing.

"2. All candidates were required to be practicing physicians legalized to practice by state laws. They were, therefore, doctors whom any person might have called into his own home when a member of his family was sick.

"3. All candidates for the Medical Corps were, prior to their acceptance for service, examined by a board of qualified and especially selected physicians and surgeons. These boards were mostly composed of Medical Reserve Corps officers who, in some cases, placed too high an estimate on the men they passed upon, hence attention has been given to checking up their work and calling before boards for re-examination all whose work does not clearly establish their ability to meet the standards set.

"During the first six months of the war, 228 Medical Reserve officers were discharged for all causes. On November 1, the Surgeon General sent a letter to commanding officers of medical units, calling attention to the War Department's provision for the examination of reserve officers as to 'capacity, qualifications, conduct and efficiency.' Since November 1 there have been 822 discharges in less than four months and discharges are continuing at the rate of fifty a week. The rate of discharges was again increased by a letter sent by the Surgeon General on December 14 to department and division surgeons and commanding officers of hospitals outlining action to weed out incompetents by (*a*) psychological examination for mental capacity; (*b*) transfer of those unsatisfactory in their present work to other duties, to work involving no care of the sick for those who had been found unsatisfactory in that branch; (*c*) further instruction for those needing it; and (*d*) elimination from the service of 'men who by reason of physical or mental incapacity, viciousness, or laziness can not be made competent officers.'"

Two More Medical Officers Court-martialed.

Two more medical officers are being tried by court-martial for neglect of duty. These trials were ordered on the report of an investigation of conditions in the hospital at Camp Doniphan, which investigation was instigated by a letter written by the father of Pvt. Hestwood to Henry J. Allen and which was given very wide publicity. Although Mr. Hestwood did not, in his letter, seem to hold the medical officers to blame for the conditions of which he complained, those in command of military affairs have evidently found sufficient cause for holding these men for trial. We quote from the Official Bulletin, March 2—

"The investigation disclosed that prior to the date of Pvt. Hestwood's death (December 28) and for a considerable period thereafter, conditions in the hospital were nothing short of deplorable; in fact, the conditions cited by Pvt. Hestwood's father in his letter of January 14 to Henry J. Allen were found to be substantially correct.

"During this period the hospital was in charge of Maj. Phillip B. Connolly, Medical Corps, who is held to be responsible for such conditions.

"There were many causes which produced these conditions, some of which can not rightfully be charged to the local authorities. When the hospital was first established the medical officers were untrained in military hospital ways and organization; the enlisted personnel was almost wholly untrained; there were no female nurses; there was a shortage of supplies, due to the unusual number of patients which flooded the hospital; there was a long delay in completing the hospital; total lack of near-by laundry facilities; lack of sewerage and plumbing, etc.

"As a result of the investigation instructions have been issued by the War Department directing trial by court-martial of the then commanding officer of the hospital, Maj. Phillip B. Connolly, Medical Corps, United States Army, and of First Lieut. Walter H. Kirkpatrick, Medical Corps, National Guard, who was the first medical officer to examine Pvt. Hestwood, and who sent him to the hospital without making known the fact that he suspected spinal meningitis.

"The report of the inspector said the wards in the hospital at Camp Doniphan, and especially the one in which Pvt. Hestwood died, were in an unclean condition; there was an insufficient supply of bed linen; there was a lack of sufficient attendants on duty at the hospital, and the small number present were men of practically no experience, and patients went for long periods without a bath or without even having their hands and faces bathed. 'In fact,' the report says, 'practically every complain made by Pvt. Hestwood's father was found by the inspector to be true.'

"Reports of the Medical Department show that an unexpectedly large number of patients overtaxed the Camp Doniphan hospital during the period of Pvt. Hestwood's illness. From 1,000 to 1,500 patients were treated between December 18 and the last of the month.

"Causes contributing to the unsatisfactory conditions at that time existing in the hospital, but which are now reported removed, were mentioned as follows in the inspector's report:

"Lack of steam-heating facilities; lack of adequate supplies of hot water; untrained officers and enlisted personnel; lack of proper amount of supplies due to the unusual number of patients admitted; climatic conditions which made it hard under the best circumstances to keep patients and wards clean; lack of proper and adequate sewerage and plumbing connections; long delay in completing the base hospital at Camp Doniphan."

It is stated that some of the causes for the conditions found could not rightfully be charged to the local authorities (which of course includes medical officers). This is very evident on reading the list of such causes, such as inadequate supplies of hot water, lack of steam heat, lack of proper sewerage and plumbing, lack of trained nurses, lack of laundry facilities and lack of supplies.

Although we have seen no statement to that effect it is reasonable to presume that all those officers who were responsible for such conditions will be given as fair and impartial trials as the medical officers receive.

"Maj. Connolly is a graduate of Bellevue Medical School, 1909; Army Medical School, 1912; appointed to Army Medical Corps from New York, February 6, 1911; appointed first lieutenant, Army Medical Corps, May 10, 1912; appointed captain

June 18, 1915; appointed major May 15, 1917. Home, New York.

"First Lieut. Walter H. Kirkpatrick, Medical Corps, National Guard, accepted commission July 30, 1917. Graduate University Medical College, Kansas City, Mo. Home, Haven, Kansas."

Prods from the Prodigal.

EDITOR JOURNAL.

MY DEAR SIR: Your editorial on Military Discipline and Medicine in the January number of the Journal is in keeping with the democracy of the times. Many of the soldiers in the ranks are as intelligent and as well qualified to fill the position as the officer over them. The time has come when an officer who has to shield his standing and dignity by the camouflage of his office—his name will soon be Dennis amongst the boys. The time was, probably, when the mass of mankind was ignorant and more brutish and that autocratic conduct would be tolerated, but that day has passed by.

The way to get the most out of a man is to keep his mentality as well as his physical condition at a normal standard, and his spirits exuberant, and his hope in the future rosy and bright. And the way to do this is for his associates, and technically present superiors, to let him see that he is worth while in their esteem, that they know he can do the work assigned to him and that he can do it well, that he is trusted to do it and the responsibility is with him. In other words, let him know by your conduct that you feel that he is an intelligent, sentient being and a coequal in the work to be done, and he will do it. Such treatment insures the health and morale of any man, be he plebian or soldier. Why it is left to the successful physician only to know this and to practice it, and a majority of the rank and file of petty army officers to lack this common sense principle, deponent saith not, unless, as your editorial gives the cue to the difference—and that is that pure militarism tends to make the average army officer brutal that the average man placed in an official military position, by his training for such place has stultified the humane in him and has substituted the ego and primitive man in him.

(We would hardly go so far as that, but we do believe that only those officers of exceptional character—and only such become great officers—can train their men to the point of perfect machine-like movement and automatic obedience, required of the efficient soldier, and still maintain a proper consideration for the human element in them.—EDITOR.)

In 1890 orders were given the surgeons in the Prussian Army to measure the chests of recruits every four weeks. All were to be regarded as "narrow-chested," the circumference of whose chests was less than half the length of their bodies. Narrow-chested men whose chests were not widened by drill were to be regarded as predisposed to tuberculosis, and were to be discharged lest they infect the healthy soldiers.

Infant mortality increases as the parent's earnings decrease. Statistics of eight American cities show that, with thirteen thousand babies, where one-fourth of the fathers earned less than $550 a year the death rate in those families was one baby in every six; whereas, when the fathers earned $1,050 per year the death rate was one in every sixteen.

The sense of taste in criminals is manifestly weak, relatively to that of ordinary individuals. Female criminals have the sense of taste still more obtuse than men of the same category. Hence some defect in the cerebral cortex. Is this true?

A plentiful supply of good food seems to increase the average stature of a people without altering the other proportions of the body. Instance: The richer classes of Paris, England and the royal families of Polynesia are taller than the average population.

Lime in drinking water (limestone districts) tends to increase the average stature of a people.

Those who live in cities for two or three generations seem to become shorter on the average.

Early marriage is said to bring about the lowering of the mean stature of a people. The shortest of all Europeans are certain Polish Jews who only average five feet four and one-half inches, and who marry at from fourteen to fifteen years of age. The Japanese, who are distinctly shorter than any other yellow race, marry at eleven and twelve years of age.

Mental and moral qualities insure the survival or dominance of a nation.

The influence of tight collars on the vision, by impeding the circulation in the head by pressing on the jugular vein, is well known to military surgeons. Forster states that three hundred cases have come under his observation—the eyesight had been affected by the disturbance of the circulation caused by wearing collars that were too small. The tendency would be to myopia (?).

There is said to be a post office down in Arkansas, named Malaria, probably from the fact that the mail service is intermittent. When it gets large enough to have a mail order office it may assume a remittant character. If this should be the case it will doubtless be continued.

A CAMOUFLAGE CLAIM.—A young lady in California sued a railroad company for an accident causing an abdominal tumor. While her suit for damage was pending against the railroad company an operation was deemed necessary and on opening the abdomen a dead fœtus at full term was found. The railroad disclaimed all responsibility for the tumor.

THE PRODIGAL.

SOCIETY NOTES.

RICE COUNTY MEDICAL SOCIETY.

The annual meeting of the Rice County Medical Society was held in Lyons on December 27. The following officers were chosen for the coming year: President, Dr. Maggie L. McCrea, Sterling; vice-president, Dr. J. H. Powers, Little River; secretary-treasurer, Dr. H. R. Ross, Sterling; censor, three years, Dr. J. S. McBride, Lyons; delegate, two years Dr. C. E. Fisher, Lyons; to give paper at state meeting, Dr. H. R. Ross, Sterling.

The society is in a prosperous condition and hopes for a year's helpful work. The year's program will be printed in a short time. H. R. ROSS, Secretary.

FRANKLIN COUNTY SOCIETY.

At the January meeting of the Franklin County Medical Society it was decided that the Society pay both the local and state dues for all members who are in active service with the army.

Dr. G. W. Davis, who has been stationed at Camp Pike for the past six months, has recently been promoted and is now a captain.

Franklin County and the city of Ottawa have been having an epidemic of measles and small pox.

Dr. G. W. Wolf has removed from Virginia to Rantoul, which has had no physician since Dr. C. C. Bennett went into the army last July.

The members of this society were disappointed when the Lecture Bureau was discontinued.

Our next meeting will be held at the residence of Dr. F. C. Herr, February 27.

H. L. KENNEDY, Secretary.

BOOKS.

The Practical Medicine Series.

Under the general editorial charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. Price of series, $10. The Year Book Publishing Co., 327 So. LaSalle St., Chicago, Ill.

Volume VII—Obstetrics—Edited by Joseph B. DeLee, A.M., M.D., Professor of Obstetrics, Northwestern University Medical School, with the collaboration of Eugene Cary, B.S., M.D., Assistant Gynecologist, St. Luke's Hospital, Instructor in Gynecology, Northwestern University Medical School. Year Book Publishers, Chicago. Price, $1.35.

Volume VIII—Pharmacology and Therapeutics—Edited by Bernard Pantus, M.S., M.D., Associate Professor of Medicine, Subdepartment of Therapeutics, Rush Medical College. Preventive Medicine — Edited by William A. Evans, M.S., M.D., LL.D., P.H.D., Professor of Preventive Medicine, Northwestern University Medical School. Year Book Publishers, Chicago, Price, $1.50.

These are volumes of Series 1917 of the Practical Medicine Series. The volumes are published at about monthly intervals and cover the entire field of medicine and surgery. Each volume is complete for the year on the subjects of which it treats.

Sanitation for Medical Officers.

Medical War Manual No. 1, by Edward H. Vedder, M.D., Lieut. Col. Medical Corps, U.S.A. Illustrated. Published by Lea & Febiger, Philadelphia and New York. Price, $1.50.

Notes for Army Medical Officers.

Medical War Manual No. 2, by Lieut. Col. T. H. Goodwin, R.A.M.C., author of Notes for Medical Officers on Field Service, and Field Service Notes for R.A.M.C., with an introductory note by Surgeon General William C. Gorgas, U.S.A. Published by Lea & Febiger, Philadelphia and New York. Price, $1.00.

These annuals are authorized by the Secretary of War and under the supervision of the Surgeon General and the Council of National Defense. They are of convenient pocket size, with flexible backs, and contain a number of blank pages for special notes or addenda.

The Surgical Clinics of Chicago.

Volume I, Number VI (December, 1917). Index number. Octavo 245 pages, 89 illustrations. Philadelphia and London: W. B. Saunders Company. Published bi-monthly. Price per year, paper, $10; cloth, $14.

Two of the very interesting articles in the December Surgical Clinics are the clinic of Dr. Herman Kretschmer presenting three cases of Tuberculosis of the Kidney, and a discussion of Prostatectomy by Louis E. Schmidt.

There are also clinics by Dean Lewis, Albert J. Ochsner, Carl B. Davis, French S. Carey, Carl Beck, Frederick A. Besley, Philip H. Kuescher, Frederick G. Dyas, Daniel N. Eisendrath and Kellogg Speed.

The Medical Clinics of North America.

Volume I, Number III (the New York number, November, 1917). Octavo of 346 pages, 37 illustrations. Philadelphia and London: W. B. Saunders Company, published bi-monthly. Price per year, paper, $10; cloth, $14.

In the November Clinics are several articles relating to diet and nutrition, one by Graham Lusk on Calories in Common Life; one by Max Einhorn on Diet in Diseases of the Kidneys; one by Warren Coleman on The Thyroid Diet; and another by Charles Gilmore Kerley on Apparent and Real Appetite Defects in the Young.

There is a very interesting contribution by Cohn on The Pharmacology of Digitalis. A good many will be interested in the paper by Robert Anderson Cooks on Protein Sensitization in the Human with Special Reference to Bronchial Asthma and Hay Fever.

Diseases of the Chest and the Principles of Physical Food for the Sick.

A manual for physician and patient. By Solomon Strouse, M.D., Associate Attending Physician, The Michael Reese Hospital; Professor of Medicine at the Post-Graduate School, Chicago; and Maude A. Perry, Dietitian at the Michael Reese Hospital, Chicago. 12mo of 270 pages. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $1.50 net.

One of the things which every physician must decide for his patient is the diet—or at least the patient seems to expect that he will. There are not many of us who are able to prescribe a diet that is suitable for the conditions demanding it and also satisfactory to the patient.

This little book by Strouse and Perry gives a very satisfactory exposition of the subject of food values, but the most practical part of it is the very carefully described diet list for the diseases in which the matter of diet is of importance. There are also some very excellent recipes for the preparation of special foods and delicacies for the sick.

Diagnosis.

By George W. Norris, M.D., Assistant Professor of Medicine in the University of Pennsylvania, and Henry R. M. Landis, M.D., Assistant Professor of Medicine in the University of Pennsylvania, with a chapter on the Electrocardiograph in Heart Disease, by Edward B. Krumbharr, Ph.D., M.D., Assistant Professor of Research Medicine in the University of Pennsylvania. Octavo volume of 782 pages with 413 illustrations. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $7 net; half morocco, $8.50 net.

The authors of this book have given very careful attention to illustrations and have thus added much to the ready comprehension of the matters presented. Among the illustrations are many sectional views of the thorax which enable the student to more easily understand the anatomical relations and aid him in interpreting the physical signs of disease. There are also

a considerable number of Roentgenograms which will give the reader an idea of what may be expected from this aid to diagnosis.

While we find nothing particularly new in this book, some of the subjects are presented in a different way. The past few years had added little of real value to our methods of diagnosis of diseases of the chest, but whatever has been developed is carefully set out by the author. The subject matter is concisely written, with no unnecessary verbiage, but nothing of importance has been omitted.

Diseases of the Digestive Organs with Special Reference to Their Diagnosis and Treatment.

By Charles D. Aaron, Sc.D., M.D., Professor of Gastroenterology in the Detroit College of Medicine and Surgery; Consultant Gastroenterologist to Harper Hospital. Second edition, thoroughly revised. Illustrated with 156 engravings, 48 Roentgenograms, and nine colored plates. Published by Lea & Febiger, Philadelphia and New York. Price, $7.

If all the facts regarding the processes of digestion, that have been reported as such, and all the theories that have been advanced, were to be compiled, a considerable number of volumes would be required to present the result. Not only the theories of normal digestive processes and of the disturbing factors in such processes, but many of the conclusions from carefully determined facts have been modified or abandoned on account of the results of further research. It will probably be many years before the final word on this subject may be written.

Dr. Aaron found that in a short time many new and important matters had become well established and required inclusion in his revised edition. The second edition seems to be complete. It covers a very extensive field of research and presents many new facts for the consideration of the student.

The author has considered the physiology of digestion from the viewpoint of the clinician and has given such attention to the influence of the internal secretions upon digestion as the progress in the study of these secretions justifies. He has given very carefully all the methods for the diagnosis of digestive diseases and has outlined the various forms of treatment that have proven of value. Naturally much attention is given to the effect of various foods and to special diets. It is a masterly work and deserves a cordial reception.

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New and Nonofficial Remedies.

Barbital.—Biethyl-Barbituric Acid, first introduced under the name Veronal. In small doses barbital is a relatively safe hypnotic, but fatalities have followed its indiscriminate use. It is claimed to be useful in simple insomnia, as well as in that accompanying hysteria, neurasthenia and mental disturbances. From 0.3 to 1 Gm. (5 to 15 grains) in hot water, tea or milk, or, if in wafers or capsules, followed by a cupful of some warm liquid.

Barbital-Abbott. — A brand of barbital complying with the New and Nonofficial Remedies standards. The Abbott Laboratories, Chicago.

Mercury Benzoate-Merck.—A brand of mercuric benzoate complying with the New and Nonofficial Remedies standards. Mercuric benzoate has the properties of mercuric chloride. It has been said to be useful for hypodermic use and in gonorrhea. Merck & Company, New York.

Chlorcosane. — A liquid obtained by chlorinating solid paraffin. It contains about 50 per cent of chlorin in stable combination. Chlorcosane is used as a solvent for dichloramine-T; with it solutions containing as much as 8 per cent may be prepared. When used in a hand atomizer, chlorcosane solutions of dichloramine-T may be made less viscous by the addition of 10 per cent of carbon tetrachloride. The Abbott Laboratories, Chicago.

Betanaphthyl Salicylate-Calco.—A brand of betanaphthyl salicylate complying with the New and Nonofficial Remedies standards. Betanaphthyl salicylate is believed to act as an intestinal antiseptic and, being excreted in the urine, to act in a similar way in the bladder. It is said to be useful in intestinal fermentations, catarrh of the bladder, particularly gonorrheal cystitis, rheumatism, etc. The Calco Chemical Co., Bound Brook, N. J.

Acetylsalicylic Acid-Merck.—A brand of acetylsalicylic acid complying with the New and Nonofficial Remedies standards. Acetylsalicylic acid is employed in rheumatic conditions, and especially as an analgesic and antiseptic in colds, neuralgias, etc.

Chlorazene Surgical Powder.—An impalpable powder composed of chlorazene, 1 per cent; zinc stearate, 10 per cent, and sodium stearate, 89 per cent. Chlorazene Surgical Powder is absorbent, slightly astringent, and forms a closely adherent film when applied to the skin. It may be dusted freely over denuded or abraded areas, cuts, wounds, and skin eruptions. The Abbott Laboratories, Chicago. (Jour. A. M. A., Feb. 16, 1918, p. 459.)

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National Conference of Social Work.

Social service necessary because of war conditions and the reconstructional work that must be taken up in every community at the close of the war will be the principal subjects stressed at the great forty-fifth National Conference of Social Work to be held in Kansas City May 15-22. The trend of the entire conference will be along war service lines.

More than 4,000 representative social workers from every part of the United States will attend the conference. The speakers will include men and women whom the Government has called to organize its army, navy and industrial centers on the highest degree of social welfare.

Such men as Raymond Robins, in charge of Red Cross work in Russia; Ernest P. Bicknell, director general of the Red Cross work in the United States; Homer W. Folk, formerly president of the New York State Charities and Associations, now in charge of the department of civil affairs of the Red Cross in France, will have important places on the program. C. C. Stillman and Fred R. Johnson, who won national recognition by their welfare work in Kansas City, will speak on district work and training camp activities respectively.

Practically the entire force of the Playground and Recreation Association of America, besides recreation experts from the leading cities of the country, have been enlisted to lead the recreational activities of the soldiers and promote constructive social reforms in towns and cities adjacent to cantonments.

Among the great women speakers will be Mrs. Florence Kelly, one of a committee of three asked by the Government to inspect factories where soldiers' uniforms are made and to see that none are made in sweat shops. Maud E. Minor, the only woman member of the New York State Probation Commission, and chairman of the Committee on the Protection of Girls of the War Department, will be here for a special session and several conferences.

Housing conditions will be presented by Henry H. De Loss, associate director of the Public Service Reserve of the United States Employment Service of the Department of Labor, this problem being the first war labor question taken up by the new advisory council of the federal bureau.

Prison labor, which is to be utilized to increase production for the Government and to make salvage from the wastage of cities, will be presented by E. Stagg Whitin, who has been commissioned by President Wilson to supervise this work. The progressive people of the Middle West cannot afford to miss this great conference and its helpful influence which will color the social legislation of every state in the nation for years to come.

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State Quotas of Babies to Be Saved During Children's Year.

The Children's Bureau of the U. S. Department of Labor announced recently the number of lives each state is asked to save in the campaign to save 100,000 babies and young children during Children's Year beginning April 6. Announcement of the purpose to wage such a campaign was made some time ago by the Children's Bureau and the Child Welfare Department of the Woman's Committee of the Council of National Defense, and the response, which has surpassed all expectations, indicates that efforts to promote the health and welfare of children are to be more vigor-

ous this year than ever before.

The saving of 100,000 lives of children under five is only one part of the big program for the welfare of 30,000,000 children under fifteen in the country. It is realized by all concerned that the standards of child protection must not be relaxed during war time, and the United States is expected to profit by the experience of other warring countries, where the importance of safeguarding childhood is emphasized as never before.

The campaign to save 100,000 lives of babies and young children in the United States during the second year of the war is to be inaugurted by a National Weighing and Measuring Test beginning April 6, the anniversary of the declaration of war by this country. In announcing the quotas the Children's Bureau said:

"In order that each state may feel responsible for a definite number of lives to be saved, quotas have been assigned to the various states, the apportionment being made on the basis of the population under five according to the 1910 census. This of course cannot take account of the varying death rates in the different states where death rates are known.

"In about half the states of the country, comprising nearly one-third the population, the registration of deaths was not sufficiently complete to warrant their inclusion in the registration area when the latest reports were published. The registration of births is seriously deficient in a still larger number of states. For that reason the apportionment of quotas of infant lives to be saved could not be made upon the basis of the infant mortality rate, which is based on the number of deaths under one year and the number of recorded births. Thus the only basis for the assignment of quotas uniformly applicable to all the states is the population as shown by the federal census. As the effort for the hundred thousand lives applies to the specially hazardous period of life under five years of age, the quotas are calculated upon the basis cf the population under five.

"In making the apportionment on this basis it was realized that a high mark is thus set for states in which the death rate among young children is already low. On the other hand, the mark set may be low for some states where the child death rate is excessively high. It does not appear to be possible to avoid some situations of this kind by any method of apportionment that could be devised with the data now at hand. If the registration of births and deaths were complete in all the states, an apportionment of quotas of the 100,000 lives to be saved by the various states could be made upon a different basis."

Plans for the celebration of Children's Year, of which the saving of 100,000 lives is one feature, are being developed by the Children's Bureau in co-operation with the Child Welfare Department of the Woman's Committee of the Council of National Defense. The safeguarding and protection of children is looked upon as a patriotic duty in view of the unavoidable wastage of human life incident to war. It is expected that the 5,000 or more local committees of the Child Welfare Department of the Woman's Committee will be able to carry the campaign to every community in the United States. This is looked upon as essential to the success of the movement, for in the last analysis, every community must save its own babies if they are to be saved at all. State and federal agencies, either official or voluntary, can make plans and offer suggestions, but each community must bear its full share of responsibility in making the campaign a success.

The quotas assigned to the various states are given in the following table:

	Population Under Five, 1910 Census	Quota of Lives to Be Saved
Maine	71,845	676
New Hampshire	39,581	372
Vermont	34,171	321
Massachusetts	328,886	3,094
Rhode Island	54,098	509
Connecticut	112,244	1,056
New York	898,927	8,455
New Jersey	266,942	2,511
Pennsylvania	884,270	8,318
Ohio	479,475	4,510
Indiana	275,524	2,592
Illinois	597,989	5,625
Michigan	298,554	2,808
Wisconsin	256,171	2,410

Minnesota	226,840	2,134
Iowa	236,063	2,220
Missouri	360,503	3,391
North Dakota	82,399	775
South Dakota	73,489	691
Nebraska	140,096	1,318
Kansas	191,519	1,802
Delaware	20,045	188
Maryland	137,714	1,295
District of Columbia	26,669	251
Virginia	268,825	2,529
West Virginia	169,118	1,591
North Carolina	332,792	3,130
South Carolina	228,459	2,149
Georgia	376,641	3,543
Florida	96,956	912
Kentucky	294,503	2,770
Tennessee	294,591	2,771
Alabama	311,716	2,932
Mississippi	259,661	2,442
Arkansas	230,701	2,170
Louisiana	224,069	2,108
Oklahoma	241,904	2,275
Texas	538,984	5,070
Montana	38,323	360
Idaho	40,444	380
Wyoming	15,331	144
Colorado	82,562	777
New Mexico	45,285	425
Arizona	24,778	233
Utah	52,698	496
Nevada	6,383	60
Washington	108,756	1,023
Oregon	60,211	566
California	193,659	1,822
Total	10,631,364	100,000

Medical Mobilization.

For the purpose of completing the mobilization of the entire medical and surgical resources of the country, the Council of National Defense has authorized and directed the organization of a "Volunteer Medical Service Corps," which is aimed to enlist in the general war-winning program all reputable physicians and surgeons who are not eligible to membership in the Medical Officers' Reserve Corps.

It has been recognized always that the medical profession is made up of men whose patriotism is unquestioned and who are eager to serve their country in every way. Slight physical infirmities or the fact that one is beyond the age limit, fifty-five years, or the fact that one is needed for essential public or institutional service, while precluding active work in camp or field or hospital in the war zone, should not prevent these patriotic physicians from close relation with governmental needs at this time.

It was in Philadelphia that the idea of such an organization was first put forward, Dr. William Duffield Robinson having initiated the movement resulting in the formation last summer of the Senior Military Medical Association with Dr. W. W. Keen as president—a society which now has 271 members.

Through the Committee on States Activities of the General Medical Board the matter of forming such a nation-wide organization was taken up last October in Chicago at a meeting attended by delegates from forty-six states and the District of Columbia. This committee, of which Dr. Edward Martin and Dr. John D. McLean — both Philadelphians — are respectively chairman and secretary, unanimously endorsed the project. A smaller committee, with Dr. Edward P. Davis, of Philadelphia, as chairman, was appointed to draft conditions of membership, the General Medical Board unanimously endorsed the committee's report, the Executive Committee—including Surgeons General Gorgas of the Army, Braisted of the Navy, and Blue of the Public Health Service—heartily approved and passed it to the Council of National Defense for final action, and the machinery of the new body has been started by the sending of a letter to the state and county committees urging interest and the enrollment of eligible physicians.

It is intended that this new corps shall be an instrument able directly to meet such civil and military needs as are not already provided for. The General Medical Board holds it as axiomatic that the health of the people at home must be maintained as efficiently as in times of peace. The medical service in hospitals, medical colleges and laboratories must be up to standard; the demands incident to examination of drafted soldiers, including the reclamation of men rejected because of comparatively slight physical defects; the need of conserving the health of the families and dependents of enlisted men and the preservation of sanitary conditions—all these needs must be fully met in time of war as in time of peace. They must be met in spite of the

great and unusual depletion of medical talent due to the demands of field and hospital service.

In fact, and in view of the prospective losses in men with which every community is confronted, the General Medical Board believes that the needs at home should be even better met now than ever. The carrying of this double burden will fall heavily upon the physicians, but the medical fraternity is confident that it will acquit itself fully in this regard, its members accepting the tremendous responsibility in the highest spirit of patriotism. It will mean, doubtless, that much service must be gratuitous, but the medical men can be relied upon to do their share of giving freely, and it is certain that inability to pay a fee will never deny needy persons the attention required.

It is proposed that the services rendered by the Volunteer Medical Service Corps shall be in response to a request from the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, or other duly authorized departments or associations, the general administration of the corps to be vested in a central governing board, which is to be a committee of the General Medical Board of the Council of National Defense. The state committee of the medical section of the Council of National Defense constitutes the governing board in each state.

Conditions of membership are not onerous and are such as any qualified practitioner can readily meet. It is proposed that physicians intending to join shall apply by letter to the secretary of the Central Governing Board, who will send the applicant a printed form, the filling out of which will permit ready classification according to training and experience. The name and data of applicants will be submitted to an executive committee of the State Governing Board, and the final acceptance to membership will be by the national governing body. An appropriate button or badge is to be adopted as official insignia.

The General Medical Board of the Council of National Defense is confident that there will be ready response from the physicians of the country. The Executive Committee of the General Medical Board comprises: Dr. Franklin Martin, chairman; Dr. F. F. Simpson, vice chairman; Dr. William F. Snow, secretary; Surgeon General Gorgas, U. S. A.; Surgeon General Braisted, U. S. Navy; Surgeon General Rupert Blue, Public Health Service; Dr. Cary T. Grayson; Dr. Charles H. Mayo; Dr. Victor C. Vaughan; Dr. William H. Welch.

Vocational Re-Education.

The vocational and educational problems involved in the rehabilitation of disabled soldiers and sailors are analyzed and discussed by the Federal Board for Vocational Education in Senate Document 167, just published under the title, "Rehabilitation of Disabled Soldiers and Sailors—Training of Teachers for Occupational Therapy."

Emphasis is placed on the immediate and pressing demand for the training of teachers of occupational therapy to take care of the handicapped men on their return from France. It is estimated that for every 1,000,000 men overseas, a minimum of 1,200 teachers will be needed. What must be the qualifications of these teachers in view of the experience of the belligerent countries; how they may be trained; what problems are to be met; and how they are to be met in the course of vocational rehabilitation; the social and economic aspects of rehabilitation; and the need for a national system for the rehabilitation of the maimed and crippled in industry as well as in war, are the main topics of the bulletin. The document is written by Elizabeth G. Upham, under the direction of Charles H. Winslow, assistant director for research of the federal board.

The emergency program outlined in the report is summarized as follows:

The returned disabled men are divided into four classes: 1, those who are per-

manently invalided; 2, those who are able to work, but cannot engage in competitive occupations; 3, those who must learn new occupations in the light of their handicaps; 4, those who are able to return to their former occupations. About 80 per cent of all the disabled fall into the fourth group, and about 20 per cent into the third group. The first two groups are relatively small.

For Group 1 the treatment prescribed is "invalid occupations," which are occupations that help pass the time and save the patient from brooding. For Group 2, those who will in all probability be unable to compete in any line of work, simple occupations are prescribed to be carried on under the guidance of occupational therapeutists. Such occupations as wicker furniture making, chair caning, toy making and semi-trades, will be taught these men.

For the 20 per cent who must learn new occupations a more elaborate course of rehabilitation is suggested. This will include simple occupations such as are taught to the men of the second group, followed by courses in general education wherever necessary, and followed in turn by prevocational education; that is to say, elementary vocational education; and, lastly, by vocational education in whatever line is best adapted to the qualifications and hapdicap of the man.

A similar curriculum is proposed for the 80 per cent who will probably be able to return to their old occupations. Under the lead of the occupational therapeutist the patient will be gradually taught simple occupations, his general education will be "brushed up" and the deficiencies supplied, and he will be re-educated so as to resume his former trade in spite of his handicap.

The federal board presents in this bulletin an outline of an emergency course covering eight weeks for the training of teachers to handle all four groups of disabled men. It is expected that a fraction of the disabled men themselves will serve as instructors. Nurses and teachers of arts and crafts will be available for the invalid occupation work; trained and selected women of education with previous experience in the arts, crafts and the "semi-trades" will be drawn on to teach simple occupations to Group 2. In addition to these, there will be need in Groups 3 and 4 of vocational teachers, preferably men, and men and women teachers, in general education subjects, instructors in manual training, commercial subjects, mechanical drawing, drafting, etc. Teachers of each group should have had practical experience in hospitals or institutions, and it is recommended that teachers in Groups 3 and 4 should have experience in the same line of work in the military hospitals of Canada.

That every dollar invested by the Government in the vocational rehabilitation of disabled soldiers and sailors will bring handsome returns in national efficiency is maintained in the report. "If the war should finally end in economic exhaustion," says the report, "that nation will ultimately triumph which is best able to use over again her men. It is claimed that Germany uses 85 to 90 per cent of her disabled men back of the lines, and that the majority of the remaining 10 to 15 per cent are entirely self-supporting. Belgium, whose depletion has been the greatest, was the first nation successfully to use over again her men. Not only has the large Belgium re-education center of Port Villez been self-supporting, but in addition it has paid back to the Belgian Government the entire capital cost of installation. * * *

"Economic necessity has made possible the results achieved in Belgium. For the other nations not so hard pressed the repopulation may be an important and perstrengthening of the vitality of the civil population may be as important and perhaps a determining point in their economic future. It is certain that our own economic future depends to a large extent upon the rehabilitation of those disabled both in war and industry."

The bulletin discusses at length the possibilities of development of occupational therapy and the equipment needed for all the groups described. Suggested blanks for

keeping the records in the curative workshops and for hospital registration are included.

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Navy's Call for Binoculars, Spyglasses and Telescopes— "The Eyes of the Navy."

The Navy is still in urgent need of binoculars, spy glasses and telescopes. The use of the submarine has so changed naval warfare that more "eyes" are needed on every ship in order that a constant and efficient lookout may be maintained. Sextants and chronometers are also urgently required.

Heretofore the United States has been obliged to rely almost entirely upon foreign countries for its supply of such articles. These channels of supply are now closed, and as no stock is on hand in this country to meet the present emergency, it has become necessary to appeal to the patriotism of private owners to furnish "eyes for the navy."

Several weeks ago an appeal was made through the daily press, resulting in the receipt of over 3,000 glasses of various kinds, the great majority of which has proven satisfactory for naval use. This number, however, is wholly insufficient, and the navy needs many thousands more.

May I, therefore, ask your co-operation with the navy, to impress upon your subscribers, either editorially, pictorially or in display, by announcing, in addition to the above general statement, the following salient features in connection with the navy's call:

All articles should be securely tagged, giving the name and address of the donor, and forwarded by mail or express to the Honorable Franklin D. Roosevelt, Assistant Secretary of the Navy, care of Naval Observatory, Washington, D. C., so that they may be acknowledged by him.

Articles not suitable for naval use will be returned to the sender. Those accepted will be keyed, so that the name and address of the donor will be permanently recorded at the Navy Department, and every effort will be made to return them, with added historic interest, at the termination of the war. It is, of course, impossible to guarantee them against damage or loss.

As the Government cannot, under the law, accept services or material without making some payment therefor, one dollar will be paid for each article accepted, which sum will constitute the rental price, or, in the event of loss, the purchase price of such article.

Posters are now being distributed throughout the country making an appeal to fill this want of the navy.

As this is a matter which depends entirely for its success upon publicity, I very much hope that you will feel inclined to help the navy at this time by assisting in any way that lies within your power.

Very sincerely yours,
FRANKLIN D. ROOSEVELT,
Assistant Secretary of the Navy.

℞

Absorption and Excretion of Mercury.

It may be regarded as clearly established that, in addition to the kidneys, the stomach may participate in this eliminatory function quite as well as the other portions of the alimentary tract. The occurrence of severe intoxications from the use of mercuric chloride in vaginal douches is likewise recognized. The absorption of mercury through the sound skin has been in dispute. To account for the efficacy of mercurial inunction, the contention has been made that the mercury thus applied is volatilized and absorbed through the lungs in greater part if not entirely. Experiments in the dermatologic laboratories of the Philadelphia Polyclinic leaves little doubt that the skin is an important, perhaps the most important path of absorption of mercury applied by inunction. (Jour. A. M. A., Feb. 9, 1918, p. 392.)

℞

A permanent emulsion of cod-liver oil is made by taking equal parts of lime water and the oil. Add a small quantity of oil of wintergreen to flavor. It will agree with a weak and delicate stomach that will not tolerate the pure oil.

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WANTED—A good doctor in a town of 400 population, good community and country to work in. For further information write to City Clerk, Bison, Kan.

The Dust Hazard.

T. G. Miller and H. F. Smyth, Philadelphia (Journal A. M. A., March 2, 1918), report the results of investigations on the atmospheric dust to which workmen are exposed in various industrial occupations. The dust samples are secured directly from the air, at the respiration level, by means of the Palmer apparatus, the accepted standard of the American Public Health Association. Its advantages are the large volume of air it permits to be sampled and the possibility of continuous operation over a considerable length of time. Their results were based on samples from two hundred cubic feet of air, requiring forty minutes of continuous operation for that amount. First, the normal amount of dust in the atmosphere in Philadelphia and in the adjoining country, both in and out of doors, that could be determined as standards was established. Outdoor country air showed under 20,000 particles per cubic foot with 2.2 mg. of solids in each hundred cubic feet. Indoor country air gave under 25,000 particles with 5.4 mg. of solids per hundred cubic feet. Outdoor city air contained about twice as many particles as country air with 7.8 mg. of solids per hundred cubic feet, and laboratory air averaged about six times as many particles with three times the weight. Country air contained relatively fewer of the smallest countable particles. Results of tests on eleven dust samples from three Portland cement plants are given. They were averaged as a whole and also by the presence or absence of exhaust ventilation. Tests from flint grinding and steel grinding industries showed, strikingly, the value of wet processes. Examinations of dusts in the asbestos fiber weaving and pottery industries showed the effect of exhaust hoods. Organic dust amounts were tested

(Continued on page xv)

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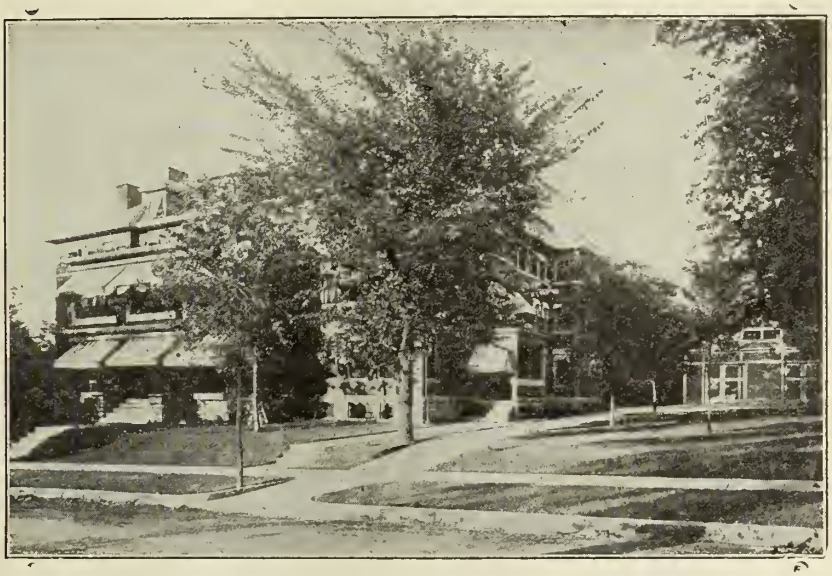

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in plush, blanket and carpet weaving establishments, felt hat establishments, cigar factories, and silk factories, and are given in tabular form. A remarkable uniformity in the percentage of different sized particles in all the tests was observed. The dustiness is much greater in the inorganic class, yet almost one-half of the so-called organic dusts is mineral in nature. The effect of humidity is shown to decrease the percentage of larger particles and increase that of the smaller ones. The average amount of dust per day inhaled in different occupations is also tabulated from careful estimations. Nasal obstruction largely favors the entrance of dust into the lungs. While these tests cannot show all the variations of dustiness, as they admit, they offer the following as some of their impressions derived from the work: "In the dustiest industry included in our survey, cement manufacture, no appreciable variations were suspected except in the packing department. In the flint mills the production was constant in the crushing department, but in the ball grinding department it was greatly increased when the cylinders were charged or emptied; at no time, however, was the air even comparatively free from dust. In the asbestos mills, no appreciable variations were probable. In the pottery kiln room, dust was an appreciable factor only when saggers were being packed or emptied. Elsewhere in the potteries conditions were more uniform. In the machine shop and in the ball-bearing grinding room there were intervals of comparative quiet, and of a decrease in dustiness around each machine. Much more variation in dust production occurred in the textile mills and other factories producing organic dusts." The order of the industries studied, in regard to dustiness, as determined by weight, was (1) Portland cement; (2) plush, carpet and blanket; (3) flint grinding; (4) steel grinding; (5) asbestos; (6) felt hat; (7) pottery; (8) cigar, and (9) silk. The order as determined by the count of particles was the same except that in the asbestos,

(Continued on page xvii)

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the plush, carpet and blanket and the felt hat industries, the count was somewhat lower on account of the presence of fibers, which could not be included in the counts. The so-called organic dusts were always mixed with inorganic material, which they think may possibly account for some of the harmful effects attributed to them. The organic dusts were less in weight and count of particles than the inorganic. The percentage distribution of the different sized particles was curiously similar in all the samples. Dust removal at the point of production not only decreases air dustiness, but particularly removes the smaller 22—MEDICAL JOURNAL Rich particles. Air dustiness varies inversely with atmospheric humidity, and the substitution of wet processes for dry tends to greatly lessen it.

———℞———

Hernia.

J. C. Bloodgood, Baltimore (Journal A. M. A., Feb. 23, 1918), calls attention to a small group of hernias that can be readily recognized at the first examination, but which are more liable, than others, to recur or fail to be cured by operation. They can be recognized when the patient is examined lying flat on his back. If the finger is pressed against the scrotum and pushed up into the external ring, as the index finger passed through the external ring (the hernia having been reduced) it usually meets an obstruction (the conjoined tendon) and is deflected upward and outward following the course of the so-called internal ring. In this smaller group the index finger meets no obstruction, but enters at once into the peritoneal cavity. Now and then one gets the impression that it does this in other cases, but if the patient is asked to raise his head, the non-contracting rectus muscle pulls tight the relaxed conjoined tendon and the examiner readily recognizes that it is not absent but simply relaxed. In those cases in which the examination detects the complete absence of the conjoined tendon, the ordinary operation for inguinal hernia fails to

(Continued on page xviii)

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cure in about 50 per cent of the cases, according to Bloodgood's observations. After his first observation of this in 1898, Bloodgood devised and published a description of the transplantation of the rectus muscle to take the place of the conjoined tendon, and this he found had been independently worked out by Woelfler in 1898. Later, Halsted modified the transplantation of the rectus muscle by turning down a pedunculated flap of the anterior sheath of the rectus. He calls attention to this class, thinking it may be of service to examining physicians of the large cantonments now in use.

Calcium Iodide in Tuberculosis.

There appears to be no work to indicate that the intravenous administration of calcium iodide in tuberculosis is of value. It has not been demonstrated that tuberculosis is associated with a deficiency of calcium. On the other hand, experiments demonstrate that the administration of calcium does not change the calcium content of the blood. Furthermore, there is no evidence to warrant the intravenous administration of iodides. (Jour. A. M. A., Feb. 16, 1918, p. 481.)

The Carrel-Dakin Wound Treatment.

William H. Welch writes that he was most favorably impressed with the Carrel treatment of wounds, and believes that Carrell should receive credit for calling attention to the possibility of the sterilization of infected wounds by chemical means. He holds that while undoubtedly the technic of the Carrel treatment is elaborate and requires an intelligence and skill on the part of the surgeon which cannot be counted on for the average surgeon, and that while the preparation of the neutral solution of sodium hypochlorite also requires chemical skill, surgeons should acquaint themselves with the principles and technic, and try to overcome the difficulties of applying the treatment. (Jour. A. M. A., Dec. 8, 1917, p. 1994.)

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Vol. XVIII TOPEKA, KANSAS, APRIL, 1918 No. 4

War-Time Nutrition.

C. FERDINAND NELSON, M.D., Ph.D.

Professor of Biological Chemistry, University of Kansas, Lawrence.

The problem of nutrition is always an important one. In peace as well as in war considerations involving the food supply of a nation must be considered of prime importance and worthy of our very best thoughts and efforts. In the strenuous times in which we are now living, this problem becomes even more acute and important. It behooves every man and particularly the physician to think seriously about questions of this sort, so that each one may do his bit effectively. Never before have there been such demands on the physician to become the preacher. The solution of this problem is largely his, and in a measure the health and healing of the nation both in a specific and in a larger sense are burdens which must be placed on his shoulders, and which he must cheerfully and ungrudgingly be willing to carry. It is with this thought in mind that I venture to review briefly some of the work which has been done along these lines and try to indicate the condition of nutritional science at the present moment.

In the year 1877 Atwater began in a large way to study the nutritive problems of the American people. His work, familiar to all and important as it is, we need not review at present. We do want to remember, however, his valuable services along these lines and to credit him with blazing the trail and preparing the way for much subsequent work that has been of immense value.

We are wont to say that man's food consists of five different classes of substances, viz., the proteins, fats, carbohydrates, salts and water. Each and every one of these classes must be represented in adequate proportions and a certain optimum balance between them maintained in order to secure physiological well being. This may be called the first lesson in nutritional science. Until quite recently we felt that nothing more was needed in making up so-called balanced rations. As a matter of fact our foodstuffs are today analyzed on the basis of these five classes of substances, and from such analyses the dietitian makes out the many scientific dietaries which we now have.

A few years ago Folin and his co-workers and L. L. Van Slyke were able to demonstrate that the final end products of protein digestion were not proteoses and peptones but amino-acids. At about the same time Osborn and Mendel showed the importance of certain amino-acids, noticeably tryptophane and lysine, in maintaining body weight and producing growth. The work of these investigators thus put emphasis on the qualitative as well as the quantitative composition of the proteins and brought out clearly the idea that not only must there be a sufficient amount of amino-acids produced during digestion in order to suffice for body needs, but also that these amino-acids must be, to some extent at least, of a definite and specific kind. The clinician has paid very little attention to the work of Osborn and Mendel because their results, while very important from a scientific point of view,

have not had to be taken into account in the diet of man because most of the foodstuffs which he eats has a sufficient supply of these particular growth and maintenance producing bodies in them. Analyses are, however, today being made of the kind as well as the amount of the various amino-acids in our protein foodstuffs, and ere long we may well hope to see important mention made of these compounds in our textbooks on foods and dietetics. A second step, then, in nutrition, may be said to have been taken with the recognition of the need of considering the qualitative as well as the quantitative composition of the protein contained in our various foodstuffs.

We have known for some time that people living on a diet composed exclusively or almost exclusively of polished rice develop the disease called beri-beri. We also know that this disease can be cured by feeding the outer husks of the rice which have been removed in the polishing. This suggests another food accessory whose presence in small amounts at least is absolutely necessary for health. Just what these compounds in the rice polishings are, we do not know. They are not proteins, fats, or carbohydrates. Funk has called them vitamines.

Doctor Bloch noted a further deficiency disease in children fed on milk from which the cream had been very carefully removed by means of a separator. This disease affects the eyes chiefly, producing a swelling, edema and inflammation leading to blindness. This affection is readily cured if taken in time by simply resuming feeding with milk containing butter-fat or a certain proportion of cream.

McCollum, who has studied very carefully the dietary deficiencies of various foodstuffs during the past few years, finds that there are two substances which produce the above-mentioned diseases. One he calls Fat Soluble A, the other Water Soluble B. Fat Soluble A is especially abundant in milk, and fairly abundant in the leaves of plants. Butter fat and egg fat are both rich in it. Seeds contain very little, inadequate amounts in fact. Water Soluble B is abundant in most foodstuffs, although it is not found in animal or vegetable fats, in starches, polished rice, or sugars. The lack of Water Soluble B he thinks produces polyneuritis, and the absence of Fat Soluble A brings on the eye trouble mentioned above. He has further shown that seeds are practically deficient in Fat Soluble A, and while Water Soluble B is absent from fats, starches, sugars, and similar substances, Fat Soluble A is, however, present in butter-fat, in the fat from eggs, and in the leaves of green plants. Since both the adult and the growing individual require these dietary accessory factors for physiological well being, it is highly important that the daily dietary includes substances containing these factors.

With the call of economy that has justly arisen as a result of the war, there have been intrenchments along various lines in the diet of the American people. The high cost of living has been combated in various ways, probably most prominently from a scientific point of view, by the issuing of lists of foodstuffs which aim in combining foods which are cheapest and at the same time the most nutritious. These lists, however, have been made out with reference to the calorific value or energy content of the foodstuffs plus the amount of protein and have naturally ignored the presence of the accessory food factors above mentioned. Since meats have become so high in price they are being used less and less. Dairy products are also rising in price and diminishing in amount. The tendency will thus be for certain of the population to live largely on the cereals and grains. It is precisely these compounds that are, as we have mentioned before, deficient in these absolutely necessary food accessories, Fat Soluble A and Water Soluble B. A diet of this sort will therefore in the long run produce malnutrition, lowered resistance, and with these diseases of every sort. We need, as has well been pointed out by McCollum, see to it that our supply of milk products does not decrease. We need further to encourage the

raising of green vegetables. Spinach, cabbage, lettuce, califlower, and beet greens are rich in these dietary factors. It behooves us therefore as physicians to call attention to the inadequacy of the protein, fat, carbohydrate, salt content of foods, since the accessory substances above mentioned are also indispensable, and to do the utmost in our power to see to it that the supply of milk and milk products be not decreased in the families of our patrons, and that in so far as is practicable we urge the consumption of green vegetables, particularly where meat, butter, and milk are not available.

Two Cases of Interest in Relation to the Function of the Thyroid.

FRANK A. CARMICHAEL.

From the Clinics of the Osawatomie State Hospital.

A consideration of the subject of thyroid degeneration is one of peculiar interest to the profession. It would be unnecessary and superfluous to attempt to bring before you a complete discussion of the various degenerative processes effecting the thyroid in the limited time alloted for a single paper. I wish to present, however, as briefly as possible two cases for your consideration. The first a case of calcareous degeneration of the thyroid in a cretin, and the second a case of so-called benign malignancy, or slow growing malignant degeneration of the thyroid developing after complete extirpation of a cystic goiter of long duration with coincident removal of most of the parathyroid tissue. A discussion of the etiological factors in either case is unnecessary as even at the present day the most of the theories that are extant are purely hypothetical in character. As early as 1867 St. Ledger enumerated forty-three different hypotheses relative to the origin of hypoplastic anomalies of thyroidogenous origin alone. The specimen of calcareous degeneration of the thyroid is submitted because the occurrence of this particular degenerative process of the thyroid is not at all common and its occerrence in a cretin of advanced years is one of rather unusual interest.

Clinically, our interest is not in the trophic and nutritive changes resulting upon hypoplastic disturbance of the thyroid alone, but our attention is engaged because of the proven effect of the secretions of this peculiar gland upon practically all the processes of metabolism, but more particularly as related to the formative period of growth. The nomenclature relating to thyroid disturbance is in some instances lacking in comprehensive attributes. The term myxedema, for instance, in itself describes only a single condition or single symptom relating to a disturbance of this gland; that is, the infiltration of the subcutaneous tissues with mucin and consequent alteration in the dermal structures with concomitant changes in the hair, teeth and nails. Cretinism, of course, refers to a more general state, and its application, while neither anatomatically or pathologically descriptive, is clinically acceptable. It is quite true that myxedema and cretinism must be differentiated by the primary factors of dermal change that are not so evident in one as in the other. Yet the method of differentiation between these two conditions, as well as Mongolism and achondroplasia dystrophica, is based entirely upon the varying condition of subdermal infiltration.

The pathological basis for the clinical conditions under discussion is unequivocally a degenerative change, either goiterous or sclerosing of the parenchyma of the glandular structure with resultant secretory changes. The classical symptoms of cretinism are retardation of mental and physical development, trophic disturbances, producing anomalous conditions of development of the head, face, body and extremities particularly characterized by perversion of bony growth and general nutrition.

The mental changes pursue a certain ratio in reference to these hypo or aplastic changes and occupy a definite position in relation to the physical anomalies existing. They consist in improper mental development, irritability, lack of judgment, defec-

tive memory, impaired ability of observation and mental concentration, varying degrees of infantilism and frequently in deaf mutism.

The importance of the condition as a clinical entity may be inferred from the fact that in 1873 there were in France alone 120,000 Cretins. It is also interesting to note that the greatest incidence of the malady conforms to the same geographical distribution as that of goiter, and many authorities, Kocher included, are inclined to believe that goitrous changes within the thyroid are in a measure responsible for the occurrence of cretinism. In fact the statement has been made by Kocher that in those cases where the father and mother are both goitrous, cretinism in the offspring is certain to be noted.

We are not alone interested in the incidence of cretinism as a pathological entity, but we are more particularly interested in the conditions that intervene between the normally functioning thyroid and the thyroid with profoundly impaired secretory function or the cretinous thyroid. To the general practitioner this latter class is one of absorbing interest, because so frequently encountered in the so-called cretinoid types. and any anomaly in the secretory function of the thyroid is reflected in certain physical and metabolic changes producing systemic and structural changes in the body that are distinctive and clearly manifested.

The clinical case from which the pathological specimens exhibited were derived was an undoubted cretin, of many years residence in this institution. Though not deaf, she did not possess the power of making herself understood and presented the classical symptoms indicative of hypo-functionation of the thyroid. A satisfactory history of her case is unobtainable, because of the meagre data relating to her commitment, and the absolute inability to gain information either from her or from any relative. Anatomically, the thyroid appeared slightly enlarged, in situ, somewhat indurated, and irregular in outline.

PATHOLOGICAL REPORT.

On removal the thyroid was a bluish gray in color and weighed 105 grams (normal weight 28.35 grams). It was found to be nodular and indurated and sectioning could be effected in certain areas only, owing to extensive calcareous deposits. On cut surface the color varied from grayish to dark liver color, depending upon the tissue changes. Areas of calcareous deposition were found throughout the entire gland varying in size from miliary deposits to those of large bean size. Specimens of these concretions are submitted. Microscopic appearance, about 75 per cent of the gland had undergone degenerative changes characterized by extensive, fibrous, connective tissue proliferation and calcareous infiltration. None of the gland was found to be absolutely normal, microscopically, though the tissues approaching closest to the normal in general structure were located toward the center of the gland, the peripheral portions of the gland having seemed to have undergone most extensive degenerative changes. Under the microscope it was seen that some of the alveola retained a relatively normal shape and cell structure with a fairly normal staining reaction and retain in their lumen the normal colloid substance, while in other areas the glandular acini have lost their shape, the nuclei fail to stain and the center is only partially filled with colloid material probably in an altered form. We have in this gland the manifestation of three distinct degenerative types; first, primary goitrous change, secondly a marked connective tissue infiltration indicating a chronic thyroiditis, and third a calcareous degeneration probably the last to occur. It is noteworthy that the connective tissue infiltration is most dense around the calcareous deposits which would indicate that the occurrence of the inflammatory process must have been the initial process in order that subsequent calcareous deposits be made possible. A chemical analysis of the calcareous material shows it to be composed of calcium salts in the form of oxalates and urates with potassium and sodium in the form of chlorides.

To recapitulate briefly we wish to say

that the pathologic process outlined above wherein the secretory process of the thyroid has been compromised, constitutes a pathologic entity of varying degrees and somewhat similar symptoms under which are classified the conditions of myxedema, achondroplasia dystrophita, Mongolism and cretinism, that are the expressions of various degrees of involvement of thyroid function. The method of tissue change may be traced directly to the stimulating effect of the physiologic secretions of the thyroid upon the sympathetic system and its inhibitory effect upon the autonomous nervous system, thereby indirectly producing nutritive changes the most characteristic of which are manifested in defective endochondrial ossification, characteristic dermal changes affecting the skin and its appendages, sexual changes as indicated by delayed appearance of puberty or persistence through life to complete infantilism, or if the sexual function be established the occurrence of menorrhagia in women and characterized by constant blood changes in which anemia of fairly advanced grade exists with a constant mononuclear leukocytosis. The somatic changes are fairly constant in all types, the dwarfism, infantalism and general blood picture do not vary in either of the four types enumerated. As before stated their difference is one of degree rather than of kind, they alike springing from the same pathologic condition of the thyroid. A difference, however, in prognosis, doubtless due to the infiltration of the tissues with mucin, exists in the fact that while the Cretin may live to old age, the myxedematous patient pursues a progressive course terminating in death in a few years.

The second case, that of slow growing malignancy, is of interest from the fact that it corroborates the statement of prominent pathologists that malignant degeneration is prone to follow in the wake of benign goitrous conditions even of many years duration. It is of further interest from the fact that malignancy, both of the sarcomatous and carcinomatous type in the thyroid, usually presents the usual picture of rapid development and fatal termination. The usual period being from eighteen months to two years. It is characteristic of malignancy affecting functionating structures that are extremely vascular, such as the breasts, the rectum and the thyroid, to pursue an extremely rapid course. Hence the occurrence of malignancy extending over a period of years primarily recognized as metastatic without serious impairment of health, or development of cachexia, is of sufficient interest to warrant comment. The third point of interest is whether or not neoplastic tissue, derived from glandular structures, is capable of taking on and performing the functions of normal secretive glandular tissues. This has been contended by Wieboldt with reference to the liver, and the development of carcinoma in the breast where lactation has never occurred is not infrequently capable of establishing this function by irritative stimulation.

Meeting of General Medical Board of Council of National Defense.

Dedication of the Warden McLean Auditorium at Camp Greenleaf, the military medical school at Camp Chickamauga, Ga., March 11, was made notable not only because of the presence of the Surgeon General of the Army and members of his staff, as well as many distinguished medical men from military and civil life, but also because of the regular meeting there March 10 of the General Medical Board of the Council of National Defense, usually held in Washington. About 1,000 doctors, who as Medical Reserve Officers are taking the three months' course, accepted the invitation to attend, extended by Dr. Franklin Martin, member of the Advisory Commission of the Council and Chairman of the Board.

These members of the General Medical Board attended: Dr. Franklin Martin, chairman; Dr. William F. Snow, secretary; Surgeon General William C. Gorgas, Dr. Victor C. Vaughan, Dr. William H.

Welch, Dr. John Young Brown, Dr. John G. Clark, Dr. Thomas S. Cullen, Dr. Edward P. Davis, Dr. William D. Haggard, Dr. Jabez Jackson, Dr. Edward Martin, Dr. Charles H. Mayo, Dr. Stuart McGuire, Dr. John D. McLean, Dr. Hubert A. Royster.

Introduced by Dr. Martin, Surgeon General Gorgas said he knew of no more important work than the activities being developed at Camp Greenleaf; that the necessity of military medical training is obvious; also that on a visit to England five years ago he learned that the great developments in the English system had been forced by the necessities arising during the Boer War; so, he said, the United States military medical service is being developed by the exigencies now confronting us and would continue after the war. He said he gained from the British Service ideas of value for his administration.

Dr. William H. Welch read a statement giving illuminating figures as to the status in the Army and Navy. Men enrolled in the Medical Officers' Reserve Corps, and recommended to the Adjutant General's office, totaled 21,824, of whom 17,313 have accepted their commissions. Of 5,378 recommended in the Dental Reserve Corps, 5,086 have accepted. Of 1,067 recommended in the Sanitary Corps, 865 have accepted. Of 152 recommended in the Ambulance Service, 138 have accepted. There are 844 officers in the Naval Medical Corps and 103 in the Naval Dental Corps. There are 827 medical and 199 dental officers enrolled in the Naval Reserve Force. There are available in the Naval Medical Reserve Corps, retired officers, acting assistant surgeons and national naval volunteers, naval militia and coast guard, 284 men. Total of officers available for active naval service are 2,257. There are 207 chief pharmacists and pharmacists, 7,000 hospital corpsmen in the regular service and 1,000 in the reserve, making a total available for active service in these branches of 8,207. In February there was an exceedingly satisfactory decline in the admission rates for communicable diseases, as well as for all causes. In the force afloat, the situation as to pneumonia and cerebro-spinal fever is very satisfactory. Scarlet fever has been slightly more prevalent than usual but in no sense epidemic; a very satisfactory decrease in measles; mumps continues as heretofore. In the fleet there were one case of cerebrospinal fever, 20 of German measles, 35 of measles, 167 of mumps, 26 of scarlet fever, 43 of pneumonia, lobar and broncho. Health conditions afloat are highly satisfactory.

Dr. Martin, in expressing the regrets of Surgeon General Braisted, of the Navy, who was unable to be present, said: "I was in Admiral Braisted's office one morning and found him getting reports by telephone from his various naval stations. From 8:30 to 10:30 o'clock every morning he receives these reports, and gives instructions, thus keeping in constant touch."

Before introducing Past Assistant Surgean C. P. Knight of the United States Public Health Service, who reported in the absence of Surgeon General Blue, Dr. Martin read the following telegram received from General Blue:

"Washington, D. C., March 9, 1918.

"Dr. Franklin Martin, Chattanooga, Tenn.

"Request that you give publicity to the fact that Public Health Service is greatly in need of the services of competent sanitarians, particularly medical officers, sanitary engineers and scientific assistants. Salaries vary from $1,800 to $2,500 per annum. Applicants should address Surgeon General, United States Public Health Service, Washington, D. C., stating in full experience and training which they have had. "BLUE."

Surgeon Knight's report summarized the good work done under his direction since September, 1917, in the five-mile zone around Chickamauga Park, a zone having 100,000 population, including 60,000 in Chattanooga. Concrete results included: Inspection of 375 restaurants, of which 148 complied with the regulations; 39 barber shops, of which 29 have been furnished cards indicating full compliance; anti-fly campaign; examination of 2,500 employes of restaurants, barber shops and dairies,

3 per cent being dismissed because of having communicable disease; complete survey of 3,000 rural homes, accompanied by educational talks resulting in orders for installation of sanitary privies; complete survey of private water supplies; inspection of all industrial plants, with corrections under way; submission of fuller reports by physicians, and all reported cases being tabulated and investigated; inspection of all dairies; pasteurization of about 30 per cent of the milk supply; eating establishments compelled to serve pasteurized milk; thorough medical inspection of Chattanooga schools and intensive rural school surveys recommended; providing Chattanooga with full-time physician and six public health nurses by the U.S. P.H.S.; establishment of unit for treatment of venereal diseases; conference with Attorney-General of Tennessee which led to Governor Rye's order to Chattanooga Board of Health to proclaim venereal diseases a menace to the civil and military population and directing it to make regulations for control in co-operation with the Provost Marshal, and steps under way to make this a state-wide campaign; and introduction and passage of ordinances in adjacent counties providing sanitary sewage disposal. Lieutenant-Commander Knight has been made a deputy health officer by county and city authorities.

Dr. William D. Haggard, of Vanderbilt University, read a statement for the Red Cross which showed that there are twenty base hospitals on active duty abroad and fourteen others mobilized of nineteen certified as ready for immediate service. Distribution of sweaters to soldiers and sailors and all Red Cross sources totals at least 1,250,000. Authority for Red Cross work within camps has been conferred by an official order signed by the Secretary of War. Contracts for convalescent houses in four camps have been let and others will soon be signed. Twenty-seven sanitary units co-operated with federal and state authorities in February in seventeen different states. The four laboratory cars, "Reed," "Pasteur," "Lister" and "Metchnikoff," have been turned over to the Army Medical Corps. Venereal clinics are now in operation in seventeen camp cities.

Major William F. Snow reviewing the work of the Committee for Civilian Co-operation in Combating Venereal Diseases said that military medical advisors have been provided for state boards of health, municipal clinics are being placed, and an excellent moving picture film, "Fit to Fight," has been prepared to be shown at the camps as an educational measure.

Major Edward Martin, reporting for the Committee on States Activities, told of co-operation with the state societies in various ways. Reporting for the Editorial Committee, he mentioned the six manuals on medical military practice, all of which have been approved by the Surgeon General's office.

For the Committee on Surgery, Dr. Charles H. Mayo told how data on 21,000 physicians had been gathered and placed on cards convenient for the ready selection of individuals and groups suited for any given task, a duplicate set of which cards has been prepared for the use of the Surgeon General's office in France. Dr. Mayo exphasized the need of reconstructing wounded men, not only for field service, but also for labor after the war, inasmuch as the usual tide of immigration has ceased. Citing the many government activities in which medicine enters, he said these relations, he believed, could be coordinated in no way except by having a medical man as a cabinet officer. He closed with this plea for recognition of medical military men:

"Medical men must have adequate rank. They are entitled to it. For it is not as if they were at work in the military service doing work to which they are new and unaccustomed. They are working in the line to which they have given their lives. They can't do their best unless they have adequate recognition and rank."

In the absence of Miss M. Adelaide Nutting, chairman, Miss Ella Phillips Crandall, secretary, reported for the Committee on Nursing. The total nurses enrolled to

date are 18,344, of whom 10,000 have enrolled with the Red Cross since April 6, 1917. The Red Cross had supplied the army with 6,220 up to March 1, and 1,000 to the navy and Public Health service. As insufficiency of nurses in December was due in some camps to lack of housing accommodations, and in others to the fact that a larger quota has not been called for, the committee recommended to the Surgeon Generals of the Army and Navy that suitable accommodations be provided in adjacent towns where necessary; that there be a quota of not less than one nurse to six acutely ill men; that a reserve of 25 above the prescribed quota be stationed at each hospital; that Miss Anne W. Goodrich be assigned to inspect military and naval hospitals, and that superintendents of three-year training schools graduate the 1918 classes early. These recommendations received unanimous endorsement of the Executive Committee of the General Medical Board, the Surgeon Generals and the Secretary of War, since which time all demands for nurses have been met. The committee is continuing its campaign to attract young women into training schools and is co-operating in the courses to be given at Vassar College this summer for young women who shall have registered for entrance to a graduate school of nursing in October, these women then being eligible for graduation in two years instead of three. Appeals to training schools and professional registries, together with the Red Cross campaign for nurse enrollment, will, the committee believes, readily provide the 5,000 additional nurses who, it is expected, will be required by June 1; and that the total of 37,500 graduates will be furnished as needed. The committee is seeking relative rank as recognition for army and navy nurses, they having all been provided for in the War Risk Insurance Law through the committee's efforts.

Miss Crandall, also reporting for the Sub-Committee on Public Health Nursing of the Committee on Hygiene and Sanitation, told of an experiment in two states in co-operation with the Food Administration whereby Public Health Nurses are to have special instruction in food economics.

Dr. Jabez Jackson, of Christian Church Hospital, Kansas City, Mo., spoke of the need of nurses to take the place of experienced nurses who have gone into military service, saying that twelve out of fifteen nurses had gone from one hospital in his city. He advocated special attention to nurse apprenticeship in hospitals.

Introduced as president-elect of the American Medical Association, Dr. Arthur Dean Bevan expressed the confident belief that, whether the war lasts three years or five years and requires 3,000,000 men or 5,000,000 men, the medical profession will continue to stand by "until the job is finished." He said: "It is the one business of the American Medical Association to educate the profession to realize the extent of the work before it. At our great meeting in June I should like to have back with us such men as Osler and Dupage to tell us at first hand something of their work and the need for such work as theirs on the other side."

Major John D. McLean told of the progress of the plans for the Volunteer Medical Service Corps, reading the conditions of membership. This body will be open to reputable physicians ineligible to the Medical Officers' Reserve Corps because they are over the age of 55, on account of physical disability, or because of necessity for home service, or other good reason. "An organization of the doctors at home to do a something where there is a something to do," was the way Dr. McLean summarized the function of this new organization which will act when called upon by the Surgeon Generals of Army, Navy or Public Health Service. He emphasized the fact that this organization "will not protect slackers at home." Dr. McLean exhibited an attractive design proposed for insignia.

Lieutenant-Colonel Victor C. Vaughan, reporting for the Committee on Legislation, told of the request of the Army medical officers for higher rank and greater authority, and of the Owen-Dwyer Bill

(S. 3748 and H.R. 9563) now pending in Congress. He cited instances which he said indicated need for greater rank, and then read the following letter from President Wilson to Dr. Franklin Martin, endorsing the bill:

"5 March, 1918.

"My Dear Dr. Martin: I read very carefully your memorandum of February 27 about the rank accorded members of the Medical Corps of the Army and have taken pleasure in writing letters to the chairmen of the military committees of the House and Senate, expressing the hope that the bill and resolution may be passed.

"Cordially and sincerely yours,
"WOODROW WILSON."

"Dr. Franklin Martin, Advisory Commission, Council of National Defense."

The dedication exercises on Monday morning, March 11, were attended by a throng which filled the auditorium to overflowing. On the stage was a notable group of army medical officers, with a sprinkling of civilian doctors of national and international fame. Lieutenant-Colonel Roger Brooks presided. Those on the stage included: Surgeon General William C. Gorgas, Brigadier General J. B. Erwin, in command of Camp Forrest; Colonel Henry Page, Dr. Franklin Martin, member Advisory Commission, Council of National Defense and chairman General Medical Board; Colonel E. L. Munson, Lieutenant-Colonel V. C. Vaughan, Lieutenant-Colonel William H. Welch, Johns Hopkins University Medical School; Major Charles H. Mayo, president American Medical Association; Dr. Arthur Dean Bevan, president-elect American Medical Association; Dr. Edward P. Davis, Philadelphia; Major John D. McLean, Major Stuart McGuire, Major George E. deSchweinitz, and many others.

After music by the Camp Greenleaf Orchestra and invocation by Bishop Thomas F. Gailor, Episcopal Bishop of Tennessee, Dr. John G. Clark, of Philadelphia, made the speech of formal presentation of the $10,000 auditorium on behalf of Mrs. William McLean, whose son, Warden McLean, while in the officers' training camp at Ft. Oglethorpe, was accidentally killed. Colonel Henry Page, who, since his graduation from the University of Pennsylvania School of Medicine in 1894, has been continuously in the regular army and whose efficient untiring efforts have transformed the site which in 1898 was the dumping ground for the Chickamauga camp, made the speech of acceptance. He said it is his ambition to have here a great postgraduate training camp, and that he hopes to see the temporary buildings replaced by permanent structures.

He was followed by General Gorgas, who argued convincingly for military training for medical officers. He said that notwithstanding handicaps, the present American Army has established a sanitary world's record, for it has cared for 1,000,000 men and the death rate is ten men per thousand, whereas Japan during the Russo-Japanese war was deemed to have accomplished a marvel when she kept her death rate down to twenty per thousand. "This is but the beginning of Camp Greenleaf," he said. "This probably will be the focus of our medical activities." He said that Camp Greenleaf, located in the geographic center of 450,000 troops in training, seems the logical location for the one great medical training ground, with accommodations there possibly for 40,000 men, trebling its present capacity. He expressed a wish that the Council of National Defense might interest itself in such a project, and he said: "From past experiences I am sure of their interest."

Brigadier General J. B. Erwin, the commandant at Camp Forrest, adjacent to Chattanooga, in a happy speech indicative of the present cordial co-operation of the line officer with the medical branch of the service, evoked enthusiastic applause when he advocated a detention cantonment for the "laundering" of recruits before they are allowed to mingle with the men in camp —thus decreasing the chances of mumps and measles, diseases which, he said, are certain to break out wherever bodies of men are gathered in camp or barracks.

Lieutenant Colonel Victor C. Vaughan recalled a visit to Berlin in 1907 and a

talk with Wassermann, the German medical authority, in which the latter expressed a fear that the 50,000 soldiers quartered in Berlin and the other like units in other cities indicated that "some day" Germany's military leaders would plunge that country in war which might mean the dismemberment of the empire. Doctor Vaughan expressed the hope that some day he might walk through the streets of Berlin and see flying from public buildings the flag, not of France, nor of Britain, nor of the United States, but of the German Republic.

Dr. Vaughan, reverting to conditions at Chickamauga as he found them in 1898, when there was not a single microscope nor test tube in the camp, contrasted those conditions with the fact that the medical camp has here been established. He contrasted the attitude of the line officer of those days with the work-together spirit of today.

Dr. Edward P. Davis, of Philadelphia, praised the spirit of the doctors in training, and reminded the audience that physicians really entered the profession of war when they became medical students. "You are soldiers by inheritance and training," he said.

A review in the afternoon of the 12,000 men in the various medical and sanitary units, with a field hospital demonstration, had a dramatic setting. From the knoll overlooking the parade ground from the east several score of interned Germans, ranged behind the wire of their stockade, viewed the spectacle, while on the western side of the field was the immense crowd of civilian visitors who came by automobile and trolley. Well in their rear, towering high above, rose historic Lookout Mountain.

The Warden McLean auditorium building is situated in the center of Camp Greenleaf. Besides the main assembly hall there are several smaller rooms, including orthopedic museum, library and reference room, lecture rooms, study rooms and office. Since the opening of the camp 4,000 officers and 20,000 enlisted men have been trained and sent to duty abroad or to instruct at other camps.

R

New Material for the Army Medical Museum.

On duty in the Army Medical Museum of the Surgeon General of the Army, Major R. W. Shufeldt, M.C.U.S.A., has been assigned to the care of the collections, both those that have long been on exhibition in the building (14,000 more or less) as well as those now forming.

Chief among the latter is the material being forwarded here from the various battle fronts of Europe. This last is for future study with the view of preparing an exhaustive medical and surgical history of the present war. The value of what this collection will come to be, when properly prepared for use, to the physicians and surgeons of the future is quite beyond all calculation.

All this is now partially under way, but needs a generous government appropriation to render all that has been undertaken a living reality. We also have on foot the building of a new Army Medical Museum, a site for which has been given, plans executed, and other matters arranged so that it but now requires an adequate appropriation from Congress to commence the work on this most important enterprise, which makes for the advancement of everything pertaining to the interests of modern medicine, and those most interested in it.

Major Shufelt is aiming to obtain a favorable endorsement of this project in the form of resolutions, from all the leading medical and surgical societies in the country; the medical colleges; and other similar institutions; which resolutions will be incorporated with a bill to be brought, as soon as possible, before Congress for a suitable appropriation to put all this into effect even should it require three or four millions. It is the intention of those in charge of this matter to make this museum the great medical teaching and research center of the world.

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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By some unfortunate circumstance the printer failed to change the date line in the form for the front cover of the last number of the Journal, and it appeared as February instead of March. As the error was not discovered until the Journal was mailed, we were unable to make correction.

Government Control of Medicine.

At this time when the Government has assumed, or is assuming, control of so many of the public utilities, one is not particularly startled at some one's opinion that the practice of medicine will be under Government control after the war. But why after the war? Perhaps the idea is based upon the almost certain reconstruction of our economic policies after the Government control of certain utilities may have demonstrated greater efficiency or other economic advantages. Such a future for the practice of medicine is not a new conception, but has been in the minds of many of those particularly interested in Public Health Service for many years.

What the status of medicine will be after the war does not concern us nearly so much as the possibility of some immediate action on the part of the Government by which it may be able to acquire a sufficiently large number of medical officers for the needs of the army, and at the same time avoid such a depletion in civilian practice that communities may suffer for lack of attention.

No definite action of this kind has been suggested by those in authority and if anything of the kind is contemplated it will probably appear in the organization of the Volunteer Medical Corps, notice of which appeared in the last number of the Journal. We quote the following from a similar announcement in the Official Bulletin of March 29:

The Volunteer Medical Service Corps aims to enlist in the general war-winning program all reputable civilian physicians who are ineligible to the Medical Officers' Reserve Corps and who can not serve in camp, field, or base hospital because they are over 55, have slight physical infirmity, or are needed for public or institutional service.

It will be an organization of doctors at home "to do something when there is something to do" in response to calls from the Surgeon Generals of the Army, Navy, or Public Health Service, General Medical Board, Council of National Defense, or other duly authorized department or associations.

The purposes of the organization and the probable duties of those who become members are very indefinitely stated, and yet it is not likely that so great an undertaking would be commenced without some definite plan for its utilization. We understand that a very thorough canvas of the profession in each state will be made by the state committees. From the information obtained it will be possible to determine who are eligible and qualified for military service and who are qualified for membership in the Volunteer Corps.

While we have no authority for assuming that any other purpose than those stated in the announcement lies behind the action of the Council of Defense in authorizing the organization of this corps, we are justified in considering some of the ways in which such an organization might be advantageously used.

In the preliminary survey and in the enrolment of applicants, those who are

qualified for active military service will be made known—or as one of the officers puts it, will be "smoked out." Those who enlist in the Volunteer Corps will assume an obligation to respond to orders from the Surgeons General of the Army, Navy and Public Health Service, and other authorities.

While there is no suggestion of compulsion, it might be just as well for those who are qualified for military service to send in their applications, for it will require more than the usual amount of nerve to hold out when need for medical officers is so urgent.

It has not been possible to accept for military service only such men as are not needed at home, and at the present time, in Kansas as well as other states, there are several communities without a medical attendant and many others where additional men are needed. In nearly all of the large towns there are still physicians to spare.

Before the war there were nineteen counties in Kansas in which the population per physician was more than 1,000, and there were three counties in which it was more than 2,000. There were fifteen counties in which the population per physician was less than 600. The withdrawal of physicians for military service has changed the ratio in some of these counties very materially, while in others the difference is hardly noticeable. In Shawnee County where the population per physician before the war was 419 it is now 498, although twenty-six physicians have entered the military service. In a good many of the counties, however, in which the ratio is considerably lower than the average for the state before the war, there are communities now entirely without physicians, in some of which there were formerly two or three. If as many more Kansas physicians join the medical corps as are now in the service from this state, the average population per physician will be about 1,000, which is a very fair ratio. But the average population per physician in the state, or in the counties, is of little importance except that it shows that there are enough medical men to supply our fair proportion of the needs of the army and to take care of the people at home, if by a redistribution of physicians the ratio can be made constant in all parts of the state. This is one of the things that might be accomplished by such an organization as the Volunteer Medical Corps.

Some of those in the larger towns, who are not qualified for active military service, may be asked to go, for the period of the war, to some village or rural community where their services are greatly needed. There would be some sacrifice, but it would not be greater than is being made by the men who have so willingly given their services to the army. There would be some hardships, but nothing to compare with those endured by the men at the front. Because one is too old or is physically disqualified for active military service he is not thereby relieved of his obligation to do all he can do to further the efforts of his country in this war.

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Dr. T. C. Biddle.

Dr. Thos. C. Biddle died on Saturday, February 16, after a short illness with pneumonia. Dr. Biddle was born in Indiana and was sixty years of age at the time of his death. He graduated from Rush Medical College in 1881 and immediately located at Reading, Kansas, where he practiced medicine for six years. He then located at Emporia, entering practice with his brother there. In 1895 he accepted an appointment as Superintendent of the Osawatomie State Hospital and served in that capacity for three years. He was commissioned a Captain in the Medical Corps of the 21st Kansas Volunteers, but was later transferred to the Reserve Hospital and served with that organization in Porto Rico until the end of the war with Spain.

After his return to Kansas he was appointed Superintendent of the Topeka State Hospital, which position he still held at the time of his death.

Dr. Biddle was a very capable physician and a very popular man. He was highly

respected by the people, the profession and the State administration.

The Chicago Session of A. M. A.

The local Committee on Arrangements for the Annual Session of 1918 to be held in Chicago June 10-14, is actively engaged in perfecting plans for the comfort and entertainment of the Fellows of the Association and their guests.

All correspondence with the local Committee on Arrangements or with any of its subcommittees should be addressed to 25 East Washington Street, Chicago.

The chairman of the subcommittee on clinics, Dr. Charles F. Humiston, announces that there will be a series of clinics for the Fellows of the Association on Thursday, Friday and Saturday, June 6, 7 and 8, and on Monday and Tuesday, June 10 and 11. Further announcements regarding the clinics will appear in these columns from time to time.

Alumni and section dinners will be held on Wednesday evening from 6 to 8 o'clock so as not to conflict with other events which are being planned. The chairman of the sub-committee on alumni and section entertainment, Dr. J. H. Stowell, announces that his committee is co-operating with officers of alumni associations in arranging for reunions. The committee desires, also, to assist the officers of those sections which desire to arrange for section dinners.

More Medical Officers Needed at Once.

The Surgeon General has sent out a call for volunteers for the Medical Officers' Reserve Corps. There are (April 8) 15,174 officers on active duty, 15,000 of these will be required for service with the army in France in a very short time.

Within a few months the second draft is to be made and this followed by other drafts, and these will require a considerable number of medical officers. There are few now on the available list.

If any of you are waiting for the time when you are needed, you can go right now to the nearest board and make your application. Do not give up your practice until you are notified that you will be called. You will be given time to arrange your business.

PROGRAM

Fifty-Second Annual Convention, Kansas Medical Society, Masonic Temple, Kansas City, Kan., May 1, 2, 3.

WEDNESDAY, MAY 1.

9 to 12 a.m. — Clinics at Bethany, St. Margaret's and Bell Memorial Hospitals.

10 a.m.—Meeting of Council.

2 to 6 p.m.—Reading and discussion of papers.—Meeting of House of Delegates.

THURSDAY, 9 A.M.

War Day.

Paper—Dr. Jabez N. Jackson, Kansas City, Mo.

"The Responsibility of the Profession Toward the Disabled Soldier" (illustrated) —C. Canby Robinson, M.D., Associate Professor of Medicine, Washington University, St. Louis, Mo.

"War Experiences in a German Base Hospital"—H. E. Richter, M.D., F.A.C.S., Chicago.

"Medical Officers' Training Camp"—Col. W. N. Bispham, M.C., Medical Officers' Training Camp, Ft. Riley, Kan.

"The Needs of Medical Reserve Corps as Observed in Washington, D. C." — Dr. Franklin Martin, Member Advisory Commission, Council National Defense, Medical Section, Washington, D. C.

"The Enlarging Scope of Neurological Surgery" (illustrated)—Ernest Sachs, M. D., F.A.C.S., Professor of Neurological Surgery, St. Louis, Mo.

"War Experiences in a British Base Hospital in Northern France" (illustrated)—James M. Neff, M.D., F.A.S.C., Chicago.

Evening Session.

Luncheon and entertainment by Wyandotte County Medical Society at Scottish Rite Temple.

FRIDAY, MAY 3.

8:30 to 12—House of Delegates.—Election of Officers.—Reading and discussion of papers.

2 p.m.—Trip to Rosedale.—Papers by faculty of School of Medicine.—Luncheon.

MEDICAL SCHOOL SYMPOSIUM FRIDAY AFTERNOON

University of Kansas School of Medicine, Rosedale.

Address of Welcome—Dr. Frank Strong, Chancellor University of Kansas, Lawrence.

Papers by Members of Faculty — Dr. John Sundwall, Dr. C. S. Nelson, Dr. Ralph H. Major, Dr. M. T. Sudler, Dr. P. T. Bohan, Dr. W. K. Trimble, Dr. D. C. Guffey.

PAPERS AND DISCUSSIONS.

President's Address—Dr. Chas. S. Huffman, Adjutant General, Topeka.

"Treatment of Burns"—Dr. George M. Seacat, Cherryvale.

"Tuberculosis — Its Nervous Manifestations"—Dr. C. S. Kenney, Norton.

"Proprietary Medicines" — Dr. G. A. Blaisdell, Hutchinson.

"How and When Tonsils Should Be Removed" — Dr. Thomas L. Higginbotham, Hutchinson.

"Chyluria Case Report"—Dr. H. R. Ross, Sterling.

"Strictures of the Eustachian Tubes—Their Causes and Treatment"—Dr. E. C. Button, Great Bend.

"Report of Unusual Case of Foreign Body in Abdominal Cavity"—Dr. Alfred O'Donnell, Ellsworth.

"The Clinical Value of the Wassermann Reaction and Other Laboratory Tests in the Diagnosis of Syphilis"—Dr. H. M. Conner, Rochester, Minn.

"Infection of the Accessory Nasal Sinuses"—Dr. Geo. H. Litsinger, Topeka.

"Routine Post-Operation Measures"—Dr. Robert B. Stewart, Topeka.

"The Relation of Facial Infection and Protein Toxicity to the Upper Respiratory Tract"—Dr. J. E. Sawtell, Kansas City, Kan.

"Common Head Injuries" — Dr. E. M. Meirs, Salina.

"Care and After Treatment of Surgical Cases"—Dr. J. A. Fulton, Kansas City, Kan.

"Some Phases of Plastic Surgery"—Dr. M. T. Sudler, Lawrence, Kan.

"Office Treatment of Hemorrhoids and Rectal Diseases by a General Practitioner"—Dr. Walter Hunt, Emporia.

"History of the Epidemic of Typhoid in Eldorado"—Capt. J. L. Eyman, Eldorado.

"Unusual Prevalence of Toxemia of Pregnancy in Winter of 1918—Suggestion of Standardized Treatment of Eclampsia"—Dr. Geo. C. Mosher, Kansas City, Mo.

"Prevention of Venereal Disease"—Dr. Jos. G. Wilson, Assistant Surgeon U. S. Public Health Service, Leavenworth, Kan.

"Some of the Newer Developments in the Treatment of Diabetes"—Dr. C. F. Menninger, Topeka.

"First Aid to the Neurotic"—Dr. Maud S. Deland, Topeka State Hospital.

"Early Diagnosis of Pulmonary Tuberculosis"—Dr. F. L. Loveland, Topeka.

"Hereditary Syphilis"—Dr. W. T. McDougall, Kansas City.

"Early Operation for Prostatectomy"—Dr. Albert Smith, Parsons.

"Hematuria" — Dr. C. F. Young, Fort Scott.

"The Doctor and the Cost of Living—a Plea for Adequate Fees and Efficient Service"—Dr. Geo. W. Jones, Lawrence.

"District Board Work from a Doctor's Standpoint"—Dr. J. T. Axtell, Newton.

STANDING COMMITTEES.

1. Committee on Public Policy and Legislation—Dr. J. E. Sawtell, Kansas City; Dr. W. E. McVey, Topeka; Dr. J. F. Gsell, Wichita; Dr. Chas. S. Huffman, Topeka, president ex-officio; Dr. J. F. Hassig, Kansas City, secretary ex-officio.

2. Committee on Public Health and Education — Dr. C. C. Nesselrode, Kansas City; Dr. M. Trueheart, Sterling; Dr. T. A. Jones, Liberal; Dr. M. T. Sudler, Lawrence; Dr. O. D. Walker, Salina; Dr. S. J. Crumbine, Topeka; Dr. Emma L. Hill, Oswego.

3. Committee on Scientific Work—Dr. L. F. Barney, Kansas City; Dr. J. D. Riddell, Salina; Dr. J. W. May, Kansas City.

4. Medical Defense Board—Dr. O. P. Davis, Topeka; Dr. K. P. Mason, Cawker City; Dr. D. R. Stoner, Quinter.

SPECIAL COMMITTEES.

1. Committee on Necrology—Dr. O. D. Walker, Salina; Dr. L. F. Barney, Kansas City.

2. Committee on School of Medicine—Dr. R. G. Morton, Green; Dr. J. T. Axtell, Newton; Dr. W. C. Lathrop, Norton; Dr. L. W. Baxter, Columbus; Dr. Arch D. Jones, Wichita.

Excerpts by the Prodigal.

Twenty-five years ago it was the general opinion of the medical profession, as well as of the laity, that the mother was the safest and proper person to bring up her own baby. Statistics have proved otherwise, seemingly, and now it appears to be more dangerous for a mother to be intrusted with bringing up her own child than to farm it out.

In our larger cities, statistics show that the foundling outlives the infant sought to be raised by its mother; that the abandoned waif has a better chance of life than the plutocrat's child. The infant of the well-to-do family is petted and coddled and dosed and toasted and stuffed and doctored until its resisting power is reduced to the minimum. Whereas the abandoned child is taken in charge by efficient intelligence and cared for in a scientific, dietetic and hygienic way. The official figures of the City of New York show that of foundlings or abandoned or illegitimate children less than 11 per cent die under two years of age; of those brought up in their own families the death rate is over 17 per cent for the same period.

In a properly conducted institution these statistics are not surprising. Fresh air, the right kind of food, regular feeding, equable temperature, proper clothing, intelligent care by hygienists, old maids and a doctor when needed, insures the prolonged life of the foundling over that of the home-raised article.

What shall we do to be saved from goose-foot—commonly called flat-foot?

A bill has been introduced in the Illinois Legislature to limit the height of shoe heels to one and one-eighth inches. It is claimed by those who introduced the bill that 80 per cent of the rejections of army applicants on account of foot troubles was from flat-foot, and that these troubles were inherited from mothers who wore high-heeled shoes. At any rate flat-foot is on the increase and is evidently due, to a large extent, to high-heeled shoes.

It is an ill wind that blows no one good, and now the arch manufacturer is coming into his own.

What funny fools we human beings are. We cultivate a habit to get our systems deranged and an art to get our bodies out of shape and then spend the rest of our lives and the money accumulated and endure the pain and suffering we have brought on ourselves trying to get well or trying to coerce Nature into our way of doing or thinking—which can't be did. It doth appear that of all queer beings on this earth the tribe-bimana is the limit.

Et-cet-er-a: The Germans have taken Castoria. The British admit it, but claim that the German's can't hold it. The pressure from behind is terrific already. The Germans are evacuating all along the line. They tried to keep it hid, but it slipped out and the British got wind of it. The Germans will now appreciate the value of a "scrap of paper."

THE PRODIGAL.

New Appeal to Physicians to Enroll for War Service.

Dr. Franklin Martin, chairman of the General Medical Board of the Council of National Defense, has issued the following statement:

Increase in the number of calls to active duty of the members in the Medical Reserve Corps indicates need of enrolling physicians as new members, and the Gen-

eral Medical Board of the Council of National Defense is co-operating with the Surgeon General's Office in sending a new appeal to the medical profession.

There were (March 1) 144,869 physicians in the forty-eight states and District of Columbia. The Surgeon General's report for March 22 gives a total of 18,138 officers in the Medical Reserve Corps, and of these 14,911 are on active duty. Weekly reports indicate that the officers are being called to active duty in greater numbers than they are being admitted to the Reserve Corps.

When the declaration of war demonstrated that there would be great need for physicians, the General Medical Board of the Council of National Defense began to secure data regarding physicians throughout the country. In all, 22,309 doctors have been recommended by the Surgeon General to the Adjutant General's office for commissions in the Medical Reserve Corps—15 per cent of the doctors of the country.

In addition to the members of the Medical Reserve Corps who are called to active duty, others for various reasons—illness, accident, or other unforeseen contingency—are obliged to leave the service. So the margin is constantly being drawn upon, and the need of new members is indicated, as the Surgeon General and the Council of National Defense are desirous of having a safe margin maintained at all times.

Physicians who enroll are advised and urged not to relinquish their practice until informed by the Surgeon General's office that they are soon to be called to active service. It has been the policy of the Surgeon General's office to allow fifteen days, in order that a physician may adjust his affairs, between the time that he receives his orders and the date on which he will be expected to report.

In order to acquaint the medical profession with the great need of physicians and surgeons for work in connection with the war, representatives are being sent to various parts of the country, and will continue to be sent as needed. These representatives are addressing meetings of the doctors called by their state committees, who are co-operating with Washington.—Official Bulletin, April 2.

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Cigarette Smoking and Tuberculosis.

G. B. Webb, of Colorado Springs (Major, M.R.C., U.S.A.), publishes a short report in the March number of the American Review of Tuberculosis on the effect of inhalation of cigarette smoke on the lungs as observed in over 3,000 chest examinations of soldiers recently examined for tuberculosis. Bronchitic conditions were noted, characterized by the presence of ronchi or coarse sibilant rales and sometimes also by coarse moist rales. The majority of cigarette smokers have these ronchi while the majority of non-smokers, pipe smokers and cigar smokers do not. Among the soldiers deemed unfit for service because of tuberculosis a larger percentage of non-smokers than smokers were discharged. If non-inhalers who do not show ronchi are added to the non-smokers then 30 per cent of those discharged on account of pulmonary tuberculosis did not inhale cigarettes.

Webb concludes that his studies at least suggest that the inhalation of cigarette smoke does not aid in the outbreak of pulmonary tuberculosis.—Webb, G. B.: The Effect of the Inhalation of Cigarette Smoke on the Lungs, Am. Rev. Tub., 1918, Vol. 2, No. 1.

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Tobacco and Tuberculous Laryngitis.

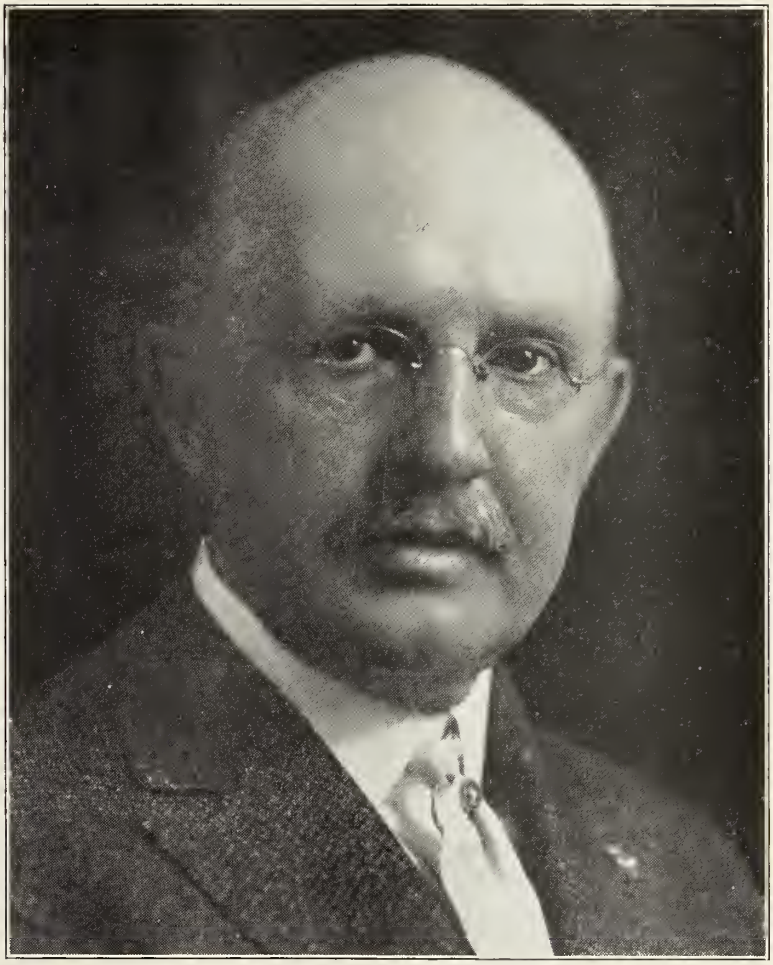
William S. Duboff, of Edgewater, Colo., reports in the March number of the American Review of Tuberculosis an attempt to check the prevalent and plausible theory that the chronic congestion of the upper respiratory passages leads to a lowered resistance to the tubercle bacillus. Three thousand histories of the Jewish Consumptives' Relief Society were carefully studied and due allowance made for possible error in the material. From his analysis he concludes:

1. Throat complications are probably no more frequent in tobacco users than in

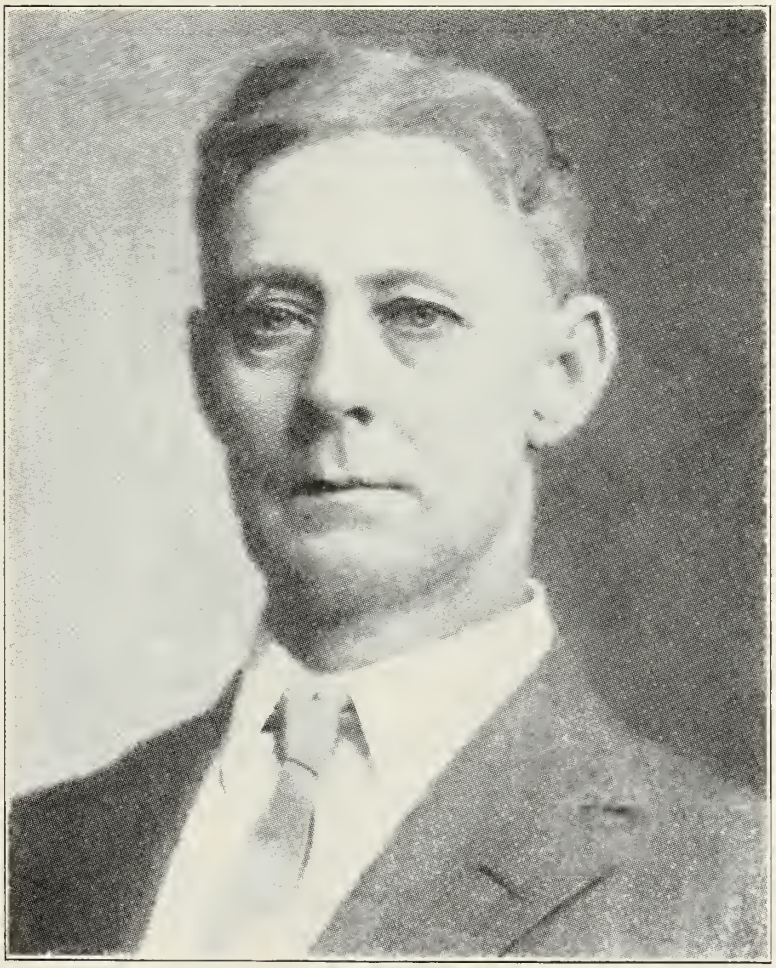
ADJUTANT-GENERAL CHAS. S. HUFFMAN
PRESIDENT KANSAS MEDICAL SOCIETY
Topeka, Kansas

CAPT. J. F. HASSIG, M.O.R.C.
SECRETARY KANSAS MEDICAL SOCIETY
Kansas City, Kansas

(Photo by Miss Reineke)



L. H. MUNN, M.D.
Treasurer Kansas Medical Society
Topeka, Kansas



LIEUT. GEO. M. GRAY, M.O.R.C.
MEDICAL MILITARY AID TO THE GOVERNOR
Kansas City, Kansas

those who use no tobacco.

2. Laryngitis, whether of specific character or not, is equally common among women as among men in the course of pulmonary tuberculosis.

3. In an equal number of men and women with pulmonary tuberculosis, the majority of throat involvements will be associated with a negative tobacco history.

4. Tobacco obviously does not predispose to laryngeal complications.—Duboff, William S.: Tobacco and Throat Complications in Pulmonary Tuberculosis, Am. Rev. Tub., 1918, Vol. 2, No. 1.

National Conference of Social Work.

What problem of social work has no medical relationship? One glance at the program of the National Conference of Social Work which will hold its forty-fifth annual session at Kansas City, Mo., May 15 to 22, would lead one to believe that practically every problem on the social worker's calendar is also a medical problem. This makes this conference one of absorbing interest to the medical profession.

What are some of these topics?

Care of Convalescents; Medical Inspection of Schools; Public Health Nursing; Hospital Social Service; Nutrition; Health Centers; A National Program of Infant Welfare; National Salvage of the Handicapped; Preparing the Soldier Incapacitated by Nervous or Mental Diseases for Return to Civil Life; this last topic is the subject of discussion by Major Richard H. Hutchings, M. O. R. C., U. S. War Department, Washington, D. C. Types of After the War Problems by E. E. Southard, M. D., Director State Psychopathic Hospital, Boston; this same topic being also discussed by C. Macfie Campbell, M.D., Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore. The Care of Feeble-Minded, Results and Significance of Mental Hygiene Work in the Army, this last by Dr. Frankwood E. Williams, Medical Director, National Committee for Mental Hygiene, New York City, are further topics of interest to the profession. Under Public Agencies and Institutions comes a discussion of private and state hospitals, sanitariums, almshouses and jails.

The battle at home against infant mortality and some reflections of Miss Julia Lathrop's efforts to save 100,000 babies this year out of the 300,000 whose lives needlessly have been lost each year is another topic that will find its way into the discussions. In short a marshalling of forces, social, industrial and medical, as a second line of defense to give battle to the untowward conditions that make social and medical work necessary, will take place at the conference, that will be second only to the efforts of our brave sons, brothers and friends battling against even greater problems "over there."

The Physicians' Supply Company, formerly at 1021 Grand Avenue, Kansas City, Mo., incorporated under the Missouri laws 1887, has just closed a ten-year lease for Lathrop Building room at 1005-07 Grand Avenue, and will reopen about May 15.

The stock will include new and complete lines of surgical and hospital supplies and specialties, special department for fitting trusses, supporters and elastic hosiery and all invalid and sick room supplies.

To Investigate Arsphenamine.

The following notice has been received from the Director of the Hygienic Laboratory of the United States Public Health Service:

April 5, 1918.

Editor Journal Kansas Medical Society.

Dear Sir.—In view of the reports in current medical literature of untoward results from the use of arsphenamine and neoarsphenamine, I have to request that you give publicity to the statement that it is requested that samples of any lots of these arsenicals which have shown undue toxicity be forwarded to the Hygienic Laboratory for examination.

In sending these samples it should be ascertained that the lot number is the same as that of the ampoules used on patients.

The samples sent should, if possible, be accompanied by a brief note stating the approximate body weight and age of the patient, the dose and dilution of the drug given, the symptoms and result; that is, whether fatal or not. Respectfully,

S. W. McCoy, Director.

SOCIETY NOTES.

CLOUD COUNTY SOCIETY.

The Cloud County Medical Society met in Concordia March 29, 1918, with the following present: Drs. Robertson, McDonald, Caton, Sawhill, Beach, Doty, Kiene, Devilbiss, Starr, and Prout. On motion, Dr. Chas. Caton was chosen chairman for the evening. On motion, Dr. W. A. Farr of Miltonvale was reinstated to membership. The following officers were elected for 1918: Dr. W. B. Newton of Glasco, president; Dr. W. S. Prout of Concordia, secretary; Dr. W. F. Sawhill of Concordia, treasurer; Dr. W. B. Beach of Concordia, delegate to the State Society. Plans were discussed for the following year and the sentiment was evidently in favor of more regular meetings in the future.

Wm. S. Prout, Secretary.

STAFFORD COUNTY SOCIETY.

The Stafford County Medical Society met in Stafford Wednesday at 3 p. m. The president, Dr. H. H. Miner, presided. The following members were present: M. M. Hart, H. H. Miner, Macksville; F. W. Tretbar, J. J. Tretbar, W. L. Butler, Stafford; Pankratz, Newell, dentists, Stafford; J. T. Scott, St. John.

Dr. V. B. Newell read a paper on Conductive Anesthesia and demonstrated the method of preparing the solutions and their administration. The paper was very interesting and appreciation was expressed by all present.

Dr. F. W. Tretbar read a paper on Cerebral Apoplexy that was instructive and elicited interesting discussion which was participated in by every member present. In closing the discussion Dr. Tretbar laid special stress upon the importance of prophylactic treatment in these cases and stated that many cases of high blood pressure, tinnitus, cerebral congestion and other prodromal symptoms could be saved from apoplectic seizures if properly instructed as to manner of living, diet, etc., and timely administration of the proper remedies.

Society arjourned to meet in St. John the second Wednesday in April.

J. T. Scott, Secretary.

FRANKLIN COUNTY SOCIETY.

Dr. H. W. Gilley, one of the oldest physicians in Franklin County, met with a painful accident March 27, when he fell from a step-ladder, breaking both bones of the left forearm and dislocating the wrist joint.

The Franklin County Medical Society met at the office of Dr. W. E. Michener, March 27, and Dr. Capell of Kansas City read a paper on Tuberculosis of the Urinary System.

Dr. D. H. Smith has moved from Richmond, Kansas, to Junction City.

The following letter was received from one of our county members, and was read to our members at our last meeting:

To the Members of the Franklin County Medical Society.

Gentlemen.—The writer has just received the February number of the Journal of the Kansas Medical Society. Among the many good things it contains is the report of the January meeting of the Franklin County Medical Society.

He is especially pleased to note the action of the Society in the matter of remission of dues of its members on active duty in the United States Army, and the payment of their dues in the Kansas Medical Society.

He appreciates this action, not for its monetary value alone, but for all that it seems to mean of commendation and approbation for the sacrifice we are making.

This action brings very close to our hearts the fellowship of kindred spirits, helps to lighten the load of daily grind in this new and unwonted field, brings to us a sense of companionship and encourages us to continue our expression of patriotism until the day when Justice and Mercy may reign secure under the banner of freedom and democracy.

He appreciates the notice you take of his promotion, that your representative in the 87th Division has been found worthy of the increased responsibility the rank implies.

From this, his fiftieth anniversary, with half a century with peace behind him and how much of war before him, he wishes to assure you that wherever the vicissitudes of service may call him, into whatever zone his orders may take him, he will try to do his duty, to conduct himself as becomes an officer in the

United States Army; that his sacrifice may bring credit to the Franklin County Medical Society, his friends, his family and loved ones, his home and his country.

GEO. W. DAVIS,
Captain Medical Reserve Corps.

Camp Pike, Arkansas, March 25, 1918.

H. L. KENNEDY, M.D.,
Secretary and Treasurer.

WILSON COUNTY SOCIETY.

The Wilson County Medical Society held its regular March meeting at the Wilson County Hospital at Neodesha at 7:30 p. m. and elected the following officers: Dr. J. W. McGnire, Neodesha, president; Dr. W. H. Addington, Altoona, vice president; Dr. C. A. Thomas, Fredonia, secretary and treasurer.

A talk was given by the retiring president, Dr. R. K. Dodge of Fall River, which was followed by interesting case reports by the doctors present. The society then adjourned to the hospital dining room and sat down to a delectable lunch served by the culinary artists of the staff. The tables were beautifully decorated with candles and cut flowers. The nurses in training at the hospital were also present at the lunch. The doctors present were: J. L. Moorhead, J. W. McGuire, C. L. Randall, O. D. Sharpe, and B. P. Smith of Neodesha; W. H. Addington, Altoona; A. W. Fairchild, Estella Fairchild and R. K. Dodge of Fall River; F. M. Wiley, A. C. Flack, W. H. Young, W. S. Cady and C. A. Thomas of Fredonia.

The war has affected the Wilson County Medical Society as it has all other societies. The honor roll consisting of Capt. E. C. Duncan of Fredonia and Lieut. A. P. Williams of Neodesha, who are in service. The following physicians also applied for commissions, but were rejected on account of physical disabilities: C. L. Randall, Neodesha; C. W. Wilson, W. H. Young, and C. A. Thomas, Fredonia. The last two are now doing their bit as examiners on the draft board.

C. A. THOMAS, Secretary.

Of the one hundred sixty-nine graduates of the Kansas Medical College located in Kansas, fifty have accepted commissions in the medical corps of the army.

BOOKS.

The Third Great Plague.

A discussion of syphilis for every-day people. By John H. Stokes, A.B., M.D., Chief of the Section of Dermatology and Syphilology, The Mayo Clinic, Rochester, Minn. 12-mo of 204 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $1:50 net.

One is inclined to estimate the author's opinion that syphilis can easily be obliterated as rather too optimistic. There will not be many who agree with him. It is easy for medical men to "think of syphilis as a medical and sanitary problem," but the people will not readily abandon their ideas of its immorality, its association with promiscuity and prostitution, and the disgrace associated with infection.

If the everyday people—or a sufficient number of them—could be induced to read this book, or others of a similar nature, it would give them a great deal of practical information and would, no doubt, accomplish much toward the eradication of syphilis. Physicians can help in this movement by recommending this book to their patrons.

American Addresses on War Surgery.

By Sir Berkeley Moynihan, C.B., Temporary Colonel, A.M.S., Consulting Surgeon, Northern Command. 12-mo of 143 pages. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $1.75 net.

This is a collection of papers read by Col. Moynihan in this country during the months of October and November, 1917. The titles of the papers are as follows: The Cause of the War; Gunshot Wounds and Their Treatment; Wounds in the Knee Joint; On Injuries to the Peripheral Nerves and Their Treatment; Gunshot Wounds of the Pleura.

These papers will be found very interesting as well as instructive.

Infection, Immunity and Specific Therapy.

Second edition, thoroughly revised, with special reference to immunologic technic. By John A. Kolmer, M.D., Dr.P.H., M.Sc., Assistant Professor of Experimental Pathology, University of Pennsylvania, with an introduction by Allen J. Smith, M.D., Professor of Pathology, University of Pennsylvania. Octavo of 978 pages with 147 original illustrations, 46 in colors. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $7 net; half morocco, $8.50.

In his first edition Kolmer gave us what

seemed to be a most comprehensive review of all that was known on these subjects. The fact that a revision is so soon required simply means that the development of new theories and new facts has made it necessary, and considerable new material has been added to that in the former edition. The author has been very careful to give the proper technique for all the procedures required in the specific treatment of diseases.

With the growing importance of antitoxins, serums and vaccines, it is essential that every practitioner should be accurately informed as to their use and the results to be expected.

Bastedo's Materia Medica, Pharmacology, Therapeutics, Prescription Writing.

By W. A. Bastedo, Ph.D., M.D., Associate in Pharmacology and Therapeutics at Columbia University, New York. Octavo of 602 pages, illustrated. Cloth, $3.50 net. Philadelphia and London: W. B. Saunders Company.

With the present efficient methods for testing the therapeutic action of remedies it has been necessary for us to frequently revise our methods of treatment and many of our text-books have become valueless. The author of this book has recognized "that, as a result of research, many of the hitherto valued drugs are falling into merited disuse; and that some that were of little value because of a wrong understanding of their action have come to have a definite place in our therapeutic aramentarium."

He has given forty pages to the discussion of Digitalis and thirty-eight pages to the discussion of Alcohol. Considerable space has also been given to the consideration of epinephrin and pituitary extract. What is definitely known of the therapeutic action of drugs is very carefully set out.

Medical Clinics of North America.

Volume 1, Number 4 (the Boston number, January, 1918). Octavo of 401 pages, 128 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper, $10; cloth, $14.

Dr. Henry A. Christian presents some very interesting and instructive clinics on cardiac diseases in this number of the Clinics. Dr. Elliott P. Joslin gives a clinic on Diabetes, and Dr. John L. Morse gives one on Empyema in Children, and Dr. Graves presents a paper on Ovarian Organotherapy. These are but a few of the very interesting articles to be found in this number, but they are suggestive of the character of its contents.

The Surgical Clinics of Chicago.

Volume II, Number 1 (February 1918). Octavo of 226 pages, 73 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper $10, cloth $14.

In the February number of the Surgical Clinics there are reports of the clinics of Drs. Andrews, Ochsner, Halstead, Bevan and McArthur. There is a clinical talk by Major Kellogg Speed on Gunshots of the Head. One of the very interesting reports in this number is the clinic by Dr. Chas. A. Parker: A Non-operative Clinic Illustrating Therapeutic Measures Employed in a Variety of Orthopedic Conditions.

International Clinics.

Volume I of the Twtney-Eighth Series. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia, with the collaboration of Charles H. Mayo, M.D. Published by J. B. Lippincott Company, Philadelphia and London. Price, $2.50.

In this volume there are reports of clinics by Bishop, Hawes, Polak, Lespinasse, Kritschmer, Lahey, Cumston. There are papers on Medicine by Brown, Funk and Weber, and a general review of Medicine by Craig and Skillern. There are papers on Surgery by Lee and Biggs. It is a cloth-bound volume of 300 pages and well illustrated.

A Safe Antiseptic.

In view of the numerous reports of death and disaster following the use of bichloride of mercury and carbolic acid, it is a good thing to know that there is now available a germicidal agent which is even more efficient than these dangerous antiseptics, and which is safe. The medical profession owes much to the genius of Dr. H. D. Dakin, who has recently brought to its attention the great value of the chlorine-carrying compounds.

The most convenient of the antiseptics which he has introduced is para-toluene-sodium-sulphochloramide, best known in this country under the name of "Chlorazene." In Dakin and Dunham's "Handbook of Antiseptics," we learn that this antiseptic is more powerful, when tested on blood-serum-muscle-extract cultures of the staphylococcus aureus, than mercuric chloride, silver nitrate, argyrol, zinc chloride, hydrogen peroxide, phenol, and other common antiseptics. In fact, a 2 per cent solution of this antiseptic will accomplish in five minutes what it requires twenty-four hours to accomplish with a 1:1000 solution of mercuric chloride.

The most gratifying fact of all is that Chlorazene is safe. There is little or no danger of poisoning.

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The Bulgarian Bacillus as a Remedial Agent.

A simple and e....ective remedy for the summer diarrheas and other common ailments of the intestinal canal is the Bulgarian bacillus. This was popularized a few years ago by the late Professor Metchnikoff, who pointed out that this organism, in the form of buttermilk, is extensively used by the Bulgarians, who have the reputation of being the longest-lived people in Europe. While this lactic acid organism is not, of course, a panacea for senility, it is a remedy of very great value for many intestinal affections. Clock and others have shown that by its use summer diarrheas of children can be controlled more quickly, and with less disturbance of the child's regular food, than with any other remedy. It has also been recommended for intestinal indigestion, autotoxemia of intestinal origin, and even for such serious diseases as diabetes.

It is important to use a culture of the Bulgarian bacillus which you can depend upon. Galactenzyme (Abbott) is such a culture. This product is made from the Type A organisms, of established virility, under the most careful, aseptic precautions. It is available both in tablet form and in bouillon. For ordinary use the tablets are generally preferred. We recommend a careful trial of Galactenzyme in cases of summer diarrhea. Now is the time to procure a supply.

℞

Femile Sterility.

T. C. Stelwagen, Jr., and P. S. Pelouze, Philadelphia (Journal A. M. A., April 6, 1918), say that while valuable work has been done on the bacterial flora of the female genitalia, little appears to have been done as regards the possible effects of such flora in procreation. They report a case of a woman who had been under the care of an eminent gynecologist for a year and a half, for the purpose of correcting an apparent sterility without effect, though her husband's seminal fluid contained countless numbers of very active spermatozoa. There was complete absence of vaginal discharge. The cultures taken from the vagina showed the usual flora with the predominance of diptheroids, while those from the cervical canal were purely diptheroids, showing almost all of the Westbrook types of diphtheria bacillus, with many striking metachromatic forms. Autogenous vaccines were made and used on the husband and wife. This caused the disappearance of the diphtheroids. Three months later she found herself pregnant, and later gave birth to a healthy girl baby. Since this experience they have had occasion to examine bacteriologically two cases of female sterility. In one of them diphtheroids were found in the cervical canal and in the other a study made for Dr. Alexander Randall, they predominated. Both patients are now under treatment with autogenous vaccines, but it is too early to report results. The authors hope that others will study similar cases.

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Lipovaccines.

An additional note on lipovaccines, to their preliminary (The Journal, Feb. 16, 1918, p. 427), E. R. Whitmore and E. A. Fennel, Washington, D. C. (Journal A. M. A., March 30, 1916), describe their meth-

ods of preparing, sterilizing, etc., of these vaccines. One of the principal points in the preparation is to get the bacteria from the culture medium into the oil as promptly as possible and with as little change as possible. This, they say, seems to be accomplished better by freezing and drying in vacuo than by drying in warm air. Any vegetable oil seems satisfactory as a vehicle, but it must not be irritating when injected, and must be fully, but not too rapidly, absorbed. Various methods have been tried for sterilization, but at present they are sterilizing the lanolin and oils in the autoclave at 15 pounds for fifteen minutes, and find this entirely satisfactory. In administering the vaccine, they find a needle, No. 21, B, and a gage with a canula three-fourths inch long satisfactory. The danger of fat embolism they consider slight in administering the vaccines. They emphatically warn against giving the lipovaccines otherwise than subcutaneously, and to carefully avoid introducing it into a vein. After the needle has been introduced, the plunger of the syringe should be slightly drawn out to make sure that it is not in a vein. In a previous publication they have suggested that a dysentery lipovaccine is likely to be better than a dysentery saline vaccine in that the slow absorption would reduce the reaction; and they gave some results of vaccination of animals and men with such a vaccine. They have, since then, carried on a second series of experiments, and give some of the results. They find that the vaccines can be made on a large scale "by growing the bacteria in Kolle flasks; taking off the growth with a vacuum scraper; freezing and drying in vacuo, and emulsifying in lanolin and oil by grinding in a ball mill, using glass bottles and steel balls. The oils can be sterilized by steam at 15 pounds for fifteen minutes; by heating to 90 C. for ten hours on a water bath, or by mixing with potassium iodid. We find that we can give men a dose of 3,000 million Shiga, 3,200 million 'Y,' and 2,200 million Flexner type of the dysentery bacillus in oil without marked local or general reaction. We find production of agglutinins, precipitins and bacteriolysins in the blood of vaccinated animals and men, and there is some evidence of complement fixation."

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Acidosis in Shock.

W. S. McEllroy, Pittsburgh (Journal A. M. A., March 23, 1918), reports his studies on the acidosis factor in shock. The methods of experimentation were those described by Guthrie in The Journal of October 27, 1917, p. 1,394. Essentially, they comprise strong rhythmic stimulation of the afferent nerves of dogs, under ether anesthesia. When necessary other means, such as exposure and manipulation of the abdominal viscera, were used to hasten the conditions. In later experiments peripheral nerve stimulation combined with partial cerebral anemia was found to be the most satisfactory procedure yet employed in refractory cases. Anemia was caused by temporary occlusion of arteries supplying the brain and medulla. A little blood was lost but not enough to cause a serious condition. Acidosis was studied by the indicator methods of Levy, Rowntree and Marriott for H-ion concentration, and of Marriott for reserve alkalinity, and of Von Slyke for plasma bicarbonate, the former two being used in the earlier experiments. Variations in different animals were found. The greatest variations occurred in reserve alkalinity. In the later experiments, Van Slyke's method was followed in detail and the results showing the effects of ether administration on the plasma bicarbonate, the plasma bicarbonate in shock and the effects of injection of sodium bicarbonate in shocked animals, the effect of maintaining the reserve alkalinity during shock production, are briefly summarized as follows: "In the type of experimental shock studied there was a gradual decrease in the reserve alkalinity of the blood. The decrease varied in different animals. Anesthesia was an important factor. In some instances the reserve alkalinity in shock was as great as in other animals before shock. This shows that acidosis was not an important causative factor. In no case was a

change in reserve alkalinity sufficient to account for the condition observed. In experimental primary acidosis the alkali reserve may be lowered to a degree observed in shock without producing any marked change in the condition of the animal. The injection of sodium bicarbonate into animals reduced to a terminal state by injection of acid resulted in prompt recovery. The injection of sodium bicarbonate into animals in shock was without beneficial action, although the reserve alkali was restored. Shock may be induced while the alkali reserve is maintained by injection of sodium bicarbonate." They conclude that in the type of experimental shock studied, acidosis was only one of the many secondary changes produced.

Streptococcal Infections.

E. E. Irons, Chicago, and David Marine, Cleveland (Journal A. M. A., March 9, 1918), report their experience at Camp Custer, Battle Creek, Mich., with streptococcal infections following measles, tonsillitis and other conditions. During the fall and early winter of 1917, approximately 200 cases of measles and 50 cases of rubella were treated, with complications in only three cases, otitis media in each instance in one of which a mastoid infection required operation. With the advent of colds, acute bronchitis, pharyngitis and tonsillitis in late December and early January, a number of more serious complications appeared after measles and other diseases. The first one was a soldier who succumbed to a lobular pneumonia followed by streptococcus pleurisy and empyema. The symptoms indicated lobar pneumonia but necropsy showed the form stated. Since that case all patients presenting pulmonary symptoms have been studied with the special object of detecting empyema early and instituting drainage. Without the use of the exploring needle, many cases would have undoubtedly passed for lobar pneumonia, or pneumonia following measles. A specially close watch was kept on cases of supposedly frank lobar pneumonia showing organisms classes as Type IV, and they have repeatedly detected empyema in such cases. The necropsy findings have been quite constant. In general the pathologic findings are those of septicemia with serofibrinopurulent pleurisy, pericarditis, mediastinitis, endocarditis or peritonitis, and in one case coincident arthritis. In early cases the inflammation is fibrinous, and there is much clinical evidence that the accumulation of fluid is a late and rapidly developing process. Broncho-pneumonia, more or less extensive, was present in every case, and as Mathers has pointed out, lymphatic enlargements are usually present. It is a question whether bronchitis, bronchopneumonia and finally empyema occur or whether the lesion is primarily a serous membrane infection with later involvement of the lungs. They have observed cases that might follow the order mentioned, but in others they believe the origin to be hematogenous. In all the fourteen cases coming to necropsy, streptococci (usually hemolytic) were obtained from the heart blood or spleen by culture, also from the pleural or pericardial or peritoneal exudates. None of the organisms cultivated from these cases agglutinated with anti-pneumococcic serums of Type I, II or III. In the latter part of acute respiratory infections, large numbers of cultures were made from the throats of apparently healthy soldiers, and hemolytic streptococci were found in about 70 per cent. In the majority of the cases studied, the symptoms were largely pulmonary. Physical signs were frequently misleading. One should keep in mind the fact that this type of empyema is entirely different from that following lobar pneumonia. Thorough drainage is essential, but in many cases it failed. In four of the fatal drained cases, vegetable endocarditis was found.

Tuberculin.

L. M. Ryan, Banning, Calif. (Journal A. M. A., April 6, 1918), after describing the terms used describes the tuberculin reaction. The tuberculin test probably owes its activity to the presence of a specific protein of the tubercle bacillus, either in

solution, as bacillary bodies, or as particles of such. It is undoubtedly closely related to the anaphylactic reaction. He quotes with approval the theory of Wassermann and Bruck as a working formula. According to them the reaction of tuberculin depends on a union in the lesion of the injected tuberculin with the antituberculin anchoring large amounts of complement at the site, causing the symptoms observed. If there is no reaction they presume that sufficient antituberculin is present in the serum to unite immediately with the tuberculin injected and prevent this from reaching the tuberculous focus. If the reaction is absent in advanced tuberculosis it is assumed that the cells, owing to long stimulation, can no longer furnish the antibodies. Some observers do not accept this explanation, and hold that the local traumatism at the point of injection may explain it. The comparative efficiency of diagnostic tests is told, of which the cutaneous or von Pirquet test seems to be the most efficient. Detre's modification of it is described, but Ryan does not believe that Detre's grouping can be accepted, and does not hold when the patient reacts only to the bovine tuberculin. His case is one of bovine tuberculosis, but he believes this test to be a valuable aid. The method of application is described as follows: "The arm, preferably the external surface of the upper arm, is cleansed with ethyl alcohol. Through the superficial part of the skin five abrasions are made, deep enough to remove the skin but not to draw blood. These abrasions are made with a small instrument similar to a jeweler's screw driver, by lightly boring with it into the skin. The abrasions should be about three-fourths inch apart and range in a longitudinal straight line parallel with the long axis of the humerus." Persons who do not have tuberculosis do not react to tuberculin, but there are conditions in tuberculosis in which the patient is insensitive to the test, as in extreme toxemia, with no antibodies present. Completely healed lesions will not react. Other acute conditions may mask the tuberculosis, and in very acute tuberculous infections the test may be negative. The Detre test as modified has certain advantages. It is easy in application, and is of some value in prognosis. Its absence in a case of known tuberculosis would be of bad import. Technical errors and constitutional disturbances are very rare.

———R———

Pneumonia and Empyema.

W. W. Hamburger and L. H. Mayers (Chicago), Camp Zachary Taylor, Louisville, Ky. (Journal A. M. A., March 30, 1918), make a preliminary report on the cases of pneumonia and empyema observed at Camp Zachary Taylor. In all, there were 274 patients, 176 with the lobar, and ninety-eight with the bronchopneumonia type. The early cases, in September and October, 1917, about thirty in number, apparently conformed to the usual lobar type, and only one death occurred in the series. Many of them were undoubtedly type four. The first case definitely diagnosed bronchopneumonia occurred October 22, ten days after the first measles admission From then on, the number of cases of pneumonia following measles increased rapidly, paralleling closely the measles admissions, and decreasing with them. Unlike the earlier benign lobar pneumonia, these bronchopneumonia following measles have been severe and fulminant. They developed usually the third or fourth day of the rash, and were ushered in by high temperature, rapid respiration, patchy areas of dulness, roughened broncho-vesicular breathing, bubbling rales, and especially marked dyspnea and dusky cyanosis of the face. The latter two symptoms, interpreted as evidences of air hunger, increasing in severity with the progress of the pneumonitis, were difficult to relieve. By these two symptoms one could often pick out a beginning case and estimate the chances of recovery. The majority of these cases developed in the hospital wards as close sequelae to the primary disease. At necropsy, the lungs showed areas of bronchopneumonic consolidation, and the bronchi and trachea were usually inflamed,

bronchiolitis and bronchiectasis, and a markedly dilated right auricle indicated ante mortem cardiac failure. About December 1 the fulminant atypical lobar pneumonias, later shown to be streptococcal in origin, began to appear, and continued to do so until the middle of January. Some cases began insidiously with sore throat, cough, grip, for a few days, and gradually progressed until frank signs of consolidation could be elicited. Others were severe from the first, with sudden overwhelming prostration and collapse, profoundly toxic, and fatal within three or four days, suggesting a general sepsis. These cases were most distressing and very resistant to treatment. In both these classes of cases, empyema occurred in an extremely high percentage, 86 out of 274, or 31.4 per cent. The variations in the empyema curve were separate and distinct from the pneumonic nerve per se, and were probably on account of the virulence of the invading organisms. The physical signs were most misleading. Clinically the severe prostration with flushing, dyspnea, deep boring chest pain, and asymmetric chest excursion were most prominent. Treatment was disappointing. Rib resection was ineffectual. The authors give the methods adopted, including the use of the Potain treatment, which they admit is not without danger, however. In some cases there was no evidence of pneumonia consolidation but they contained empyema pus and atelectatic lung tissue, and such might be considered primary suppurative pleuritis. "The severity and rapidity of the onset, course and termination of many cases, the overwhelming prostration and toxemia with death measured in hours, the presence of hemolytic streptococci in empyema pus, blood cultures, metastatic abscesses in joints, cellular tissues, pericardium, middle ear, mastoid, meninges and brain, and the inefficacy of treatment, all lend strong support to the view that these cases are true examples of streptococcus sepsis. The empyemas of this series are notable from the standpoint of their incidence (31.4 per cent); their early development (often primary); their rapid development (within twenty-four hours); the presence of hemolytic streptococci; their occurrence as part of a general sepsis (distinct from pneumonia); the difficulties of interpretation of physical signs; the advantages of roentgenographic examinations, and the difficulties and indications of various forms of treatment." The character of the empyema fluid gradually changes, becoming more turbid and heavier and surgical interference is best when delayed. Intracostal drainage with attached water pump for continuous suction has been found superior to other methods of surgical treatment.

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Forced Diuresis.

W. D. Sansum, Chicago (Journal A. M. A., March 30, 1918), puts on record experiments made by him to test the value of artificially increased diuresis as a remedy for diphtheria intoxication. Diphtheria toxin was selected because it was standardized and the technic followed the same general method as in his mercuric chlorid experiments. The fatal dose was determined intravenously, but not with the same degree of precision as in the mercuric chlorid work, owing to the varying of resistance in the different animals. The author says: "We found that 0.021 c.c. of the toxin per kilogram of body weight killed four out of five dogs in from three and one-half to six days. One part of the toxin in 100 parts of 0.2 per cent sodium chlorid solution was administered intravenously in each case as a single dose. When diuretic treatment was to follow, the toxin was administered with the first few cubic centimeters of the diuretic solution. Three diuretic solutions were used: (1) an alkaline hypertonic salt solution (sodium chlorid 2.2 per cent and sodium carbonate 0.371 per cent); (2) an 18 per cent glucose solution, and (3) an 18 per cent glucose solution having the salt content of Ringer's solution (sodium chlorid 0.7 per cent potassium chlorid 0.03 per cent, and calcium chlorid 0.025 per cent.)" The diuretic solutions were administered as in the experiments previously described.

In the first series more than the determined fatal dose was given. The first treated dog weighing 10.80 kg. received 30 c.c. of the alkaline salt solution per kilogram hour for three hours, and passed during that time 963 c.c. of urine. There was also a marked catharsis, which accounts for the urinary output being less than the fluid intake. The other dogs received the marginal fatal dose of toxin, and the dog that showed the largest diuretic effect produced succumbed the quickest. The treatment seemed to do harm rather than good. The same effect was observed in mercuric chlorid experiments, and in no case was life prolonged even when treatment was begun as soon as the poison was administered. This would discourage any therapeutic experiments with the method.

—R—

Our Archaic Patent Laws.

The reports of the Council on Pharmacy and Chemistry on Secretin-Beveridge and the Need for Patent Law Revision are opportune. At the request of the National Research Council the "Patent Office Society," an association of employes of the U. S. Patent Office, has created a committee to study the U. S. Patent Office and its service to science and to arts. There is no question that one of two things is needed: either a radical change in the patent law itself or the application of more brains in its administration. Now the United States Patent Law is too often used to obtain an unfair monopoly of a medicament or to abet quackery. (Jour. A. M. A., Jan. 12, 1918, p. 95.)

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Celluloid Implants.

G. B. New, Rochester, Minn. (Journal A. M. A., April 6, 1918), while noting the foreign statements regarding the use of celluloid in nasal deformities, says that he has not been able to find any reference to this use of the material in this country during the last ten years. Within the past year, however, he has himself used celluloid as an implant in the tissue over the nose, in a series of dogs and in five cases in man. Two of his six dogs became infected, but in the other four it acted as an ideal implant. In five cases in man the celluloid used was in pieces of suitable size and shape, and perforated with small holes about 1.5 mm. in diameter, and they were inserted in the usual manner of inserting nasal implants, after being sterilized by boiling. It is necessary to curve the implant by shaping it in hot water and holding it in the required position until it becomes hardened. In all five cases the wounds healed primarily with practically no reaction. They have remained in position and have given no trouble. The advantages of using this material are that it eliminates the necessity of taking an autogenous transplant; it causes practically no reaction, and is apparently not affected by the tissues; it is readily shaped and curved in hot water, and remains stiff even when trimmed quite thin.

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Sodium Bicarbonate.

Few patients will object to the taste of sodium bicarbonate if the required dose is administered dissolved in a convenient quantity of cold water. The taste may be disguised by dissolving the sodium bicarbonate in carbonated water or else by adding a little sugar and lemon juice to ordinary water. Sodium bicarbonate may also be prescribed in the form of tablets. Though it is better that these be allowed to dissolve in the mouth, in most cases they are swallowed without discomfort. (Jour. A. M. A., Feb. 9, 1918, p. 410.)

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THE JOURNAL
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Vol. XVIII TOPEKA, KANSAS, MAY, 1918 No. 5

PRESIDENT'S ADDRESS.

Some Lessons of the War.

CHAS. S. HUFFMAN, M.D., Adjutant-General, Topeka, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kan., May 1, 2 and 3, 1918.

I greet you today, on this fifty-second annual meeting of the Kansas Medical Society, under many changed conditions relating to the members of this Association. With something over 300 members of our Society now in active service in this world war, and many more to go soon, our present meeting cannot help but feel the effects and changes that the war has brought to us.

It is hard for us to concentrate our minds on the work, that should naturally require the fullest consideration at our annual meeting. But I know if your thoughts are like mine they wander away from scientific subjects and matters that should be of vital interest to us as medical men, to the boys in the trenches and to that band of heroic volunteers (and every member of the Medical Corps is a volunteer) from the medical profession, who gave up all the comforts of private life and the emoluments that go with a successful professional life to serve their country. I think it would be proper and fitting to manifest our appreciation by some token or resolution that, we at this our annual meeting, have them in mind. Why should we not have a service flag displayed at this meeting with a star for each member of the Society who is now in the service?

We are going to have many problems to solve, not only during the war but after it closes. One of these is our State School of Medicine. I, for one, am proud of the record the school has made, not only in proficiency and efficiency, but in the number of graduates who now hold commissions in the Army, also the high rank accorded our school by the Government, by giving many of its graduates preferred positions.

We cannot continue to maintain our school on the present basis. To keep up the high standard we must pay the instructors a salary so that we will be able to secure and keep the best and most able men. With increased cost of living in all lines and no increase of pay for the teaching force, it is not to be expected that we can keep teachers and instructors who are high-class men. In appointing a committee on the School of Medicine, I selected men who are not connected with the school in any way, and who live in distant parts of the state. I sincerely hope this committee will go into every phase relating to the School of Medicine, and make such a report that it can be presented to the next legislature, and have the facts presented so clearly and strongly that the legislature will readily understand the needs of the institution. I also hope that the report of this committee will call the attention of the profession throughout the state to the fact that this school needs their support. I feel that the profession generally is not as close to the school as it should be, and as the school merits. We are going to need more men in our pro-

fession than ever before, for all who are now in the service will not return. We are bound to have casualties and to take the place of these we must encourage and foster our schools of medicine.

Just a little over one year ago we entered the war, and Congress immediately passed legislation providing means for our national defense, and for a year we have been feverishly working to raise an army and add to our navy. This preparation, of course, included the necessary provision for enlarging the Medical Corps and enlisting sanitary troops, commensurate with the increase in size of our army and navy.

While we had made rapid strides in the advancement of medicine and surgery, and along lines of sanitation and hygiene, as worked out by the various boards of health and the U. S. Public Health Service, it was all done on a peace basis. At no time has so much been accomplished, in the matter of preventive medicine, as was done in the last twenty years. I need only mention what was done to prevent yellow fever and typhoid, and many other advances in curing disease, like the use of the serums and Salvarsan. All the newer ideas and advances in medical science have been applied to war conditions, and with marked success. One I might mention is that of typhoid prophylaxis. But with all this, the members of our profession lacked the essential training necessary to apply this knowledge to war needs, as we now know war, and to conditions that have developed in this, the greatest of wars. The environments surrounding an army in the cantonments, while in course of training and in the field, are so different from conditions we are used to in civil life that it seems, sometimes, our education must be done over.

The advancement made in military science relating to the medical department has opened a place for every specialty known to that science. The Government has demanded that the best men of our profession enter the service, and is furnishing the best equipment available. Every effort is being made to give each enlisted man a thorough examination and every means known to medical science is to be applied to determine a soldier's fitness.

At the beginning of the war an attempt was made to intelligently mobilize the available or eligible members of the medical profession who could enter the medical corps. The Medical Section of the National Council of Defense was formed, composed of many of the best men in the country. This was supplemented by the Medical Section of each State Council of Defense. Through these two bodies—one national and the other state—the work of getting men in the Medical Reserve Corps is being carried on. In addition to the above, the officers of the American Medical Association and state societies or associations have been called upon to assist in filling up the corps. At the beginning of the war and up to the present time the Government has depended upon volunteers for this branch of the service, but the question now on is: Will the number of volunteers be sufficient to meet the increased demands? Six or eight thousand additional medical officers will be needed, when the present or second quota of selective service men is called, which numbers 800,000.

It is now intended to classify the members of the medical profession. This is not being done officially by the Government, but unofficially through the Medical Section of the National Council of Defense. When this is done, and a careful compilation is made of the blanks which each doctor not now in the service will fill out, we can then make an intelligent estimate of all the doctors in the United States who are eligible for service. Class 1 will be those who are under the age limit of fifty-five years. Class 2 will be those who are over the age limit and disqualified for other reasons. There may come a time when it will be necessary to supply localities or hospitals with physicians, for many places are now lacking in doctors sufficient to care for the people in the community.

The bill now pending in Congress to give

medical officers increased rank is a meritorious measure and should become a law. I am led to understand that it is opposed by the Secretary of War and the General Staff, but the people, as expressed in the leading newspapers, are in favor of it, and I also understand that it has the approval of the President. There is no reason that can possibly be advanced that should be weighed against the passage of this bill, when we think of the sacrifices of the medical profession and the unselfish interest the physicians have shown in their willingness to give up their work at home to volunteer their services in this war, and the splendid work they are doing. Our allies recognize the work that is being done by the Medical Department in their respective countries, and are giving them rank commensurate with the importance of their work. The increased rank would give them authority, which they do not now have, to issue orders, and see that they are carried out, the same as any other staff department of the Army. With two and a half millions of men now under arms it is absurd to think that the Medical Corps has only a few colonels and lieutenant-colonels, and a large number of lesser rank, and only one general officer.

In the equipment and training of this large army the medical man has played just as important a part as the Ordnance, Quartermaster, or any of the other staffs or branches of the Army, and I make the plea that we should urge upon our law makers to give this proposed law careful and favorable consideration.

One-third of the two and a half million of young men of the Nation examined for military service failed to pass the examination. This should be food for thought. It indicates a lack of physical fitness in young America that is not pleasant to contemplate. With proper care we ought to make a better showing. I have taken this form a report made by Dr. E. L. Fisk, in which he cites the records of several of the local boards which had examined approximately 8,000 men, of whom about one-third were rejected, and his conclusion is that at least 60 per cent of the rejected men owe thir impairments to either *ignorance* or *neglect*.. Bad eyes and teeth were the two leading causes of rejection, and underweight the third. What is the cause of this heavy percentage of rejections? It is evidently partly due to faulty nutrition, ignorance in the use and care of the eyes; and mouth infections, which are always a menace to health, and may lead to various kinds of disease. Of the ten millions of young men between the ages of 21 and 31, more than three millions are apparently in deficient health. Evidently imperfect physique and poor health are more of a tax on the Nation's health than had been supposed. Here is one of the lessons that has been brought out by selective service. Is there not something that we as members of the Medical Profession can do to increase the Nation's power and efficiency, by preventing such defects that show such an appalling number of rejections in our young men of draft age? Is this not one of the problems that our profession should give careful consideration? We have talked much about preventive medicine, and have done much in the way of prevention of disease. The campaigns carried on by Health Departments and Boards of Health have produced splendid results. The War has been the means of showing up what I consider a very serious menace to our National life and existence; the lowering of our man-power from ignorace and neglect.

Here is a fruitful field for work and one I'm sure that will be carefully considered. War, with all the awfulness that follows in its wake, may open up the way for many reforms and improvements in our national life. We will be led to see our defects more clearly, our weaknesses will become apparent. With our opulence and self-satisfied way of living, we failed to see very far in the distance, and were satisfied to let well enough alone. We should study carefully the lessons growing out of the war. We should take our stand alongside of the other great forces, who will be ready and alert to correct the evils

and faults that war has laid bare, and we as a profession should be ready and armed to do our part in erasing the scars left by the war, and to use the great power wielded by the medical profession to make our National life stronger and better physically, and when our National life is better physically, we will be better morally. A Nation cannot be strong, unless physically strong, and our duty is to prevent disease, overcome ignorance, and see that none are neglected.

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Obstetric Clinic, Kansas City General Hospital.

GEO. C. MOSHER, Senior Attending Obstetrician, and RUFORD G. HAMILTON, Junior Attending Obstetrician.

Under the auspices of the Medical and Surgical Club, held March 12, 1918.

It gives us a great deal of pleasure to see so many of you interested in the work which every one of you who is engaged in general practice must, himself, encounter in his own experience.

Surgery of a major type is of value to you, mainly, from the point of diagnosis, and you send the patient to an expert operator in whom you have confidence. Obstetrics you will yourself manage in a great majority of instances.

I see a number of my old students here and to them the clinic must be of peculiar advantage as a contrast to methods which we taught and practiced several years ago. It is hoped that these ward walks and clinical demonstrations may attract, each month, those of you who care to follow out the demonstration of modern obstetric practice. You are always welcome.

The greatest interest which is being manifested in the domain of obstetrics and gynecology today is on the question of diagnosis, and those points which pertain to lessening shock and minimizing dangers of sepsis. We shall have in the series of cases shown today an opportunity to see how these are manifested.

The first patient, Mrs. C., is a primipara, age 32. Her blood pressure ranges from 140 m.m. to 160 m.m. Her urine shows albumin and casts. She has some headache but no other symptoms. She has been in ineffectual labor for thirty-six hours with an R.O.P., cervix somewhat softened but no engagement. We find by the tape that her McDonald measurement is 37 and by the pelvimeter that the Ahlfeld is 26, these being interpreted should indicate a fetus of 52 c.m. and weighing about seven pounds four ounces. Now, you will understand the calculation of the length of the fetus by external measurements is not exactly a mathematical one, but it is wierd and sometimes astonishing how near we come to the total length of the fetus, by the estimate which is, of course, always verified post partum by measuring and weighing the baby. The reason for delay in this case which has pelvic measurements 29-25 and 19½ c.m. is that the head has not rotated and therefore there is no adjustment possible of the head and the pelvic canal. We do not avail ourselves of the other pelvic measurements if these three are reasonably harmonious, but if either is abnormally short the internal or true conjugate and the inter trochanteric, by Whitridge Williams pelvimeter, is also taken.

Having concluded that the patient is at term and the labor being ineffectual, the cervix, having been found by rectal examination to be undilated and the presenting part free above the inlet, we are to decide as to whether we advise an immediate cesarean section, agreeing with our friend Rudolph Holmes that obstetrics is a lost art, or else we set about to assist Nature in her attempt to bring the labor to a close by means more in harmony with the plan of voluntary emptying the uterus, by trying to supply the elements to the problem which Nature has apparently failed to bring into play. That is dilatation, better flexion and more forceful efforts on the part of the pains which are stimulated by the Vorhees bag, according to the plan worked out by Charles B. Reed of Wesley Hospital, Chicago, and reported by him in S. G. and O., a series of 1,000 cases.

Please note that stress is to be put on, first, accurate diagnosis; second, failure of powers of Nature; and, third, supplying the artificial help in a manner least likely to cause shock, interference with mechanism, loss of liquor amnii or infection. All these we believe we find in the Vorhees bag properly placed and carefully watched. Barnes fiddle bag we have not found as efficacious, although some of our confreres still employ this veteran agent. You will observe we use slight anesthesia in the introduction of the bag. This is our own variation, as Dr. Reed introduces the bag without an anesthetic. We have found that the average patient is very apt to be apprehensive of any operative interference with labor and in her shrinking from being hurt she becomes panicky, delaying the process and working himself into an emotional stew which is not conducive to the best efforts to help herself because she has become exhausted. Dr. Geo. F. Pendleton, who has usually given the anesthetic for me, has acquired a facility of keeping the patient at just about the proper degree of analgesia, not a definite anesthesia, and she usually rouses as soon as we are through with the placing and filling of the bag. Dr. Buford Hamilton, my junior attending, has in the meantime folded the bag into a roll occupying the least possible space and firmly grasped it by a Paen forceps, having first satisfied himself the bag is perfect; that is, that no leaks exist. We use a metal piston syringe for filling, although Reed prefers an ordinary Davidson syringe. Our dilatation is done with a set of the old reliable Hegar's dilators graduated up to 20. The latter admits the large size bag. The dilators are introduced rapidly, as you see, to avoid unnecessary delay, and as soon as No. 20 passes readily the bag is introduced. It will be observed that we use long retractors instead of bivalve speculum. This is perhaps a matter of being more familiar with the retractors. Also the dorsal position is used rather than the lateral for the same reason. The cervix is held down firmly by two volselli, one in either lip of the cervix. This is also a refinement over some operators' technique and really is an aid in accurate placing of the dilators and the bag with the least delay.

The bag being placed is held by a long uterine dressing forceps, within the uterus, while the water is slowly forced into the cone of the rubber bulb. We secure the rubber pipe of the bag by folding it on itself and slipping on two of Pettit's funis clamps, a bit of adhesive adhering to the lower abdomen keeps the bag in position while it is doing its work. The patient is returned to bed and in a variable period from twenty minutes to six hours labor is on. It is usually somewhat shorter than a similar labor in which no artificial stimulus is employed.

Let us repeat: We have never yet ruptured the membrane nor has any patient developed, after labor is inaugurated, an infection.

You will observe that McDonald and Ahlfeld have been several times mentioned and in order to make it clear it may be well to explain just what is meant by these names used in an obstetric sense.

Several years ago Ahlfeld said it was not a matter of pride to be able to boast of having delivered a patient of a ten-pound baby, but a disgrace that the average mother should be unnecessarily mutilated and subjected to shock because of the terrific stress of a long labor, and the baby so often born asphyxiated or suffering from brain lesion due to difficult forceps operation. He devised a method of measuring the child in utero, placing one pole of the pelvimeter, thus, at the upper border of the symphysis and the other at the fundal pole of the uterus. He then read the index, subtracted 2 c.m. for thickness of the skin, and multiplied by 2, which he declared gave the length of the fetus from vortex to sole, and was able to prove it post partum. McDonald reached the same end by using a tape measure thus over the parabola described by the contour of the maternal abdomen and taking 35 c.m. as indicating a fetus of 50 c.m. total length, maintained that such a measure-

ment meant a fetus at full term. Ahlfeld took the diameter between the points of the pelvimeter and if it measured 27, he subtracted 2 for the skin and doubled the 25, which also gave 50 as the length. Now, we are not always willing to induce labor on account of the measurements alone, but in case of indication of interference we agree with Dr. Chas. B. Reed that in the cases where labor has been induced for cause, our post partum results have agreed with the ante partum calculations with at most 2 c.m. variation.

A paper which is now under preparation gives the remarkable results we have had during the past year in the treatment of twenty-one cases of eclampsia and pre-eclamptic toxemia, by a systematic plan of procedure in which the mortality has been less than in any other reports we have seen. Twenty-one cases have been under observation and all on a generalized plan. Elimination—removal of foci of infection—combating acidosis and in every instance where these prophylactic measures failed to reduce blood pressure or to clear up classical barometric readings foretelling the storm which was approaching, the uterus has been emptied and usually by the Vorhees bag method.

These cases in which convulsions have succeeded each other in rapid sequence with long hard undilated cervix which menaced the patient if she were allowed to go on in labor, cesarean section was done. Each of these patients recovered. Of the entire number all recovered but one which had been delivered before entering the hospital and who died from a general septic infection three weeks after all convulsions had ceased.

I mention these facts to show you the promise held out in regard to a system of treatment which is standardized. I hope this afternoon to be able to show you the results of this induction if you are in the hospital.

This second patient, Mrs. L., a primipara, age 22, had her last menstrual period May, 1917. Her pregnancy has been uneventful and laboratory findings negative. Her measurements show crests 28 c.m., spines 24 c.m., and Baudelocque 20; blood pressure 124 systolic and 70 diastolic; McDonald 36 and Ahlfeld 27.5, which indicates that she is probably at term and the baby 50.5 c.m. length. She will have tonight C. O. and Q. and then be allowed to await developments for forty-eight hours if nothing transpires.

The third case is a breech. Mrs. S., wife of a soldier. She entered the hospital expecting to be confined within the week. Her McDonald is 34 so as the presenting part is not engaged we estimate she will probably go over for two weeks, being kept under daily observation.

The next case, Mrs. O., a primipara, has been in labor four hours. She is a normal case, age 26, L.O.A., and is having twilight sleep given under the direction of our interne, Dr. H. H. Olsen. The remarkable thing about scopolamin in labor is the relief from shock which the woman experiences when under this semi-narcosis. While scopolamin analgesia has been greatly criticized in this country, and was originally condemned in England, a glance at recent British obstetric literature will convince one that the profession is becoming more and more appreciative of its benefits. Articles have recently appeared in the British Medical Journal, the Medical Press and Circular, and other journals giving results of cases in series commendatory in tone concerning results.

We use scopolamin when indicated especially in high-strung nervous patients and in those in which a long tedious labor is anticipated. This patient has had her second dose, the first having been narcophin gr. 5½ and scopolamin gr. 1-200; the second following in three quarters of an hour, scopolamin 1-200 alone. We have had no blue babies, no hemorrhage nor other maternal grief. The only precaution being in these cases, they must be watched throughout, as often the baby is born suddenly and unobserved otherwise, the mother being only semi-rational under her analgesia.

At 4 P.M. we have the satisfaction of

showing delivery of the patient on whose case induction with the bag was done at 11 A.M. The voluntary delivery is without incident. Your attention is called to the method of keeping the head flexed to avoid laceration and at the suggestion of Tweedy of the Rotunda Hospital, Dublin, a hemostat is clamped on the cord at the vulva to indicate by its dropping two inches outside that the placenta is out of the uterus and in the vagina. No effort is made to dislodge the placenta. A policy of watchful waiting is always best to follow at this stage.

The treatment of pernicious vomiting of pregnancy has been heretofore one of the most discouraging features of obstetrics.

We have today under our care Mrs. L., who is the fifth patient seen in the last year who has responded to the hypodermic injection of ext. corpus luteum, as suggested by Dr. John C. Hirst of the University of Pennsylvania, who has conducted a series of experiments of this type of toxemia. The patient is put to bed. Nervous excitement is controlled by sodium bromide ʒi and chloral gr. xx, by enema after a cleansing flushing of soda bicarb. Later she is given bromide gr. xxx p.r.n.

The corpus luteum is given on alternate daye $\frac{1}{3}$ c.c. and increased to $\frac{1}{2}$ c.c. and to 1 c.c. The addition of thyroid extract seems to have a beneficial effect when the pulse is running wild, but must be given cautiously, as in our experience it sometimes has an untoward effect.

Two of the patients upon whom we have used this method are multiparæ and had previously suffered therapeutic abortion in two instances each, for such intolerable vomiting that their lives were menaced by the toxemia.

Three of these patients have been delivered in good condition and two remain on the list for June. We shall be glad to have any of you who meet with pernicious vomiting to try the corpus luteum and report, so that a larger number of cases being available, a fuller trial may demonstrate the value which we are to place on this therapy.

The final branch of our service is the tragic one, "Northwest Three," in which you see our series of abortions. In these beds are the women who in fancied desperation plot the destruction of their unborn children. Some of these abortions are inevitable, of course, but the great majority are deliberately induced. We have now in the ward five cases of incomplete infected abortion; at times there are in this ward ten and fifteen admissions a week.

The results of treatment here constitute our especial pride, as we have, against much opposition, demonstrated the value of a conservative, or "hands off," policy in treating septic abortions as against active interferences.

Several years ago—to be accurate, in 1914—we began to see that the universal curettement which was fashionable at that time resulted in a vast morbidity and considerable mortality, and coming across the writings of Winter, who in 1911 showed a death rate ranging from 11 per cent to 23 per cent in various clinic centers in Europe, we became convinced that a conservative method might give better results. Since that time no abortion has been curetted in our service and we will just glance at the record and call attention to the old regime in contrast.

In the curettement series, 1909 to 1910, a hundred cases taken in series showed $22\frac{1}{2}$ days in the hospital; 72 per cent of complications, cellulitis, abscesses, etc.; mortality, 8 per cent. From 1914 until the present, these cases are treated by being placed in the modified Fowler position, given an ice bag over the abdomen, a brisk dose of mag. sulph., and when pain is excessive a hypo of morph. $\frac{1}{8}$. We have now treated 358 cases by this expectant plan and our results are: Days in hospital, $8\frac{1}{3}$; complications, 5 per cent; mortality, none. There have been two deaths, which were of women who had been curetted outside before admission.

When we view this merely from the standpoint of the taxpayer, leaving out the welfare of the patient, it is a startling pic-

ture, reducing the expense of each patient two-thirds, and of course the patient incidentally profits by the conservation. Friends and relatives of patients have stormed, and outside physicians have often criticised the negative plan of treatment. Internes look askance when the temperature moves to 105 and a foul-smelling discharge persists, but they are reassured and after observing a few cases won over to our technique.

If we may summarize the service of a day's development in the Department, we should like to call to your attention the following essential points: First, all examinations of prospective maternity patients are by external palpation, auscultation and pelvimetry. No vaginal examination is permitted in the division. Second, the McDonald and Ahlfeld measurements determine when the case is at term. Of course these are taken in connection with the calendar history of the patient. On this depends the question of the maturity of the fetus. Third, all toxemics are endangered by the burden they carry and when prophylaxis fails to relieve them, the ideal mode of induction of labor is by the Vorhees bag, rather than by digital or *accouchement force* dilatation. Fourth, patients are tranquillized by scopolamin, and suffer less from shock in twilight sleep. We have seen no blue babies, nor ill effects from the use of scopolamin, but the benefits of its exhibition are apparent to any intelligent unprejudiced observer. Fifth, infection and its attendant grief to the patient is practically ruled out of the General Hospital in "West Three" wards, by technique, isolation of cases coming in with temperature, avoidance of vaginal examination. Sixth, the waiting policy of the third stage, no attempt to deliver the placenta until the hemostat indicates it is in the vagina, is the safe and sane method of procedure. Seventh, daily examination and recording the height of fundus determines when the lying-in woman is convalescent. She goes home when the fundus is not apparent to touch above the symphysis and the lochia has been for forty-eight hours free from red or brown color.

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Some of the Activities and Interests of the General Medical Board of the Council of National Defense, April, 1917-April, 1918, as Reported at the Annual Meeting, Sunday, May 5, 1918, New Willard Hotel, Washington, D. C.

The following statement, which is authorized by the Medical Section of the Council of National Defense, is a brief summary of the report of Dr. Franklin Martin, member of the Advisory Commission and chairman of the General Medical Board of the Council of National Defense, with mention of some of the leading interests and activities of the year of the Board and of the Medical Section, presented at the annual meeting of the General Medical Board, May 5, 1918.

GENERAL.

Secretary of War Baker on April 2, 1917, authorized appointment of General Medical Board. Dr. Martin designated 35 physicians and surgeons, many of whom have since entered on active service abroad. Total now is 77. Executive Committee consists of Surgeons General of Army, Navy, and Public Health Service, Dr. Franklin Martin, Dr. W. J. Mayo, Dr. Wm. H. Welch, Dr. Victor C. Vaughan, Dr. F. F. Simpson, Rear Admiral Cary T. Grayson, and Dr. Wm. F. Snow, Secretary. The first meeting was held April 9, 1917.

Requested medical men returning from abroad to furnish information regarding conditions observed in medical services of allied armies; which information was carefully summarized for reference.

Responded to request of Surgeon General to assist in increasing enrollment in Medical Reserve Corps. Enrollments in M. R. C. have been increased from 1,800 in April, 1917, to over 21,000, of which 16,042 are on active duty.

Requested 50 medical societies to furnish lists of their members fitted to perform special work for government.

CHILD WELFARE.

Formed Committee on Child Welfare, comprising representatives of several government departments, educational institutions and national organizations, to coordinate child welfare activities, and formulated program covering problems of the child up to school age, which program has been issued to the states through the medium of the States Council Section and the Woman's Committee of the Council of National Defense.

Appointed committees (*a*) to study best graphic methods of teaching child welfare; (*b*) to study food values necessary to children and prepare dietaries; (*c*) to report best procedure as to mid-wife question in present war emergency, and (*d*) to consider advisability of investigation of institutions caring for children.

CIVILIAN CO-OPERATION IN COMBATING VENEREAL DISEASES.

Developed joint conferences of medical and lay citizens in fifty cities, with officials, to discuss plans for venereal disease clinics or law enforcement measures.

Formulated list of eight measures essential to successful campaign against venereal diseases, and sent to State Boards of Health.

Appealed to State Pharmaceutical Associations for Boards of Pharmacy to assist in eliminating sale of nostrums.

Arranged trips for lecturers who aided Boards of Health in thirty states and stimulated them to more vigorous work.

Partially as a result of correspondence with State Boards of Health, twenty-six states have adopted measures requiring reporting of venereal diseases, nine have special venereal bureaus, fourteen provide free laboratory diagnosis, six provide arsphenamine, practically or absolutely free. Only seven states classifed as complacent.

Partially as a result of letters to 1,000 mayors, forty-nine cities provide for isolation and treatment of venereal cases, fifty-one require reporting of venereal diseases, forty-three have clinics, seventy-eight are conducting educational work.

Informed editors of health bulletins and labor journals of details of campaign against venereal diseases.

Distributed printed material and sent personal and circular letters to thousands of persons in communities adjacent to army camps, enlisting their co-operation.

DENTISTRY.

Appealed to dental profession through various dental associations, materially increasing enrollment in Dental Officers' Reserve Corps.

Instrumental in having military instruction included in curricula of dental colleges, and in having applicants for enrollment in Dental Surgeons' Corps specially trained.

Co-operated with manufacturers in having dental instruments and supplies standardized.

Secured volunteer services of civilian dental profession in eliminating dental disabilities of recruits.

Recommended improved courses in dental surgery in Army and Navy medical schools.

Initiated investigation as to relation of trench mouth disease to oral and general disease.

Dental committee recommended higher rank for dentists in Army Dental Corps.

HOSPITALS.

Recommended to general hospitals reorganization of staffs, in order to release as many as possible for Army and Navy service, and urged each person whose services could be spared to apply for appointment.

Hospitals classified exhaustively as to size, convenience to transportation, equipment, and all other details.

Investigated subject of portable hospitals, and recommended purchase of limited number by the Surgeon General of the Army.

Classifed and tabulated for use of Surgeon General's office data as to private houses and large buildings offered for use as military hospitals.

HYGIENE AND SANITATION.

Recommended to War and Navy Depart-

ments that zones around camps and cantonments be placed under military control in order to protect troops from venereal infections. Encouraged organization of Fosdick Commissions or Training Camp Activities.

Appointed sub-committees on drug addictions, alcoholic control, public health nursing, tuberculosis, and health statistics, which committees have assembled information and recommended definite sanitary measures for guidance of Army, Navy, Public health Service, American Red Cross, and Civil Health Agencies.

Work of sub-committee on venereal diseases has expanded, and it has become the Committee for Civilian Co-operation in Combating Venereal Diseases, a general committee of the General Medical Board.

INDUSTRIAL MEDICINE AND SURGERY.

Instituted an Advisory Committee on Industrial Hygiene, comprising representatives from Public Health Service, Departments of Agriculture, Interior, Commerce, Labor, and of Organized Industry, Organized Labor, Organized Medicine, and Organized Industrial Medicine, for the purposes of providing against unnecessary human waste in industry and society during war, to offset drain of man-power from industry through raising of military forces to meet need for increased production, to avoid preventable deaths from accidents and disease, and to improve surroundings of workers.

LEGISLATION.

Drafted section of Army Bill eliminating sale of alcoholic drinks and prostitution in five-mile zone around camps and cantonments; indorsed by Council of National Defense, and enacted into law within ten days of original rough draft.

Induced authorities to provide for enlistment of medical students of well-recognized schools in Enlisted Medical Reserve Corps, and completion of course before being called into military service. Similar effort made in aid of pre-medical students.

Instrumental in having American concerns licensed to manufacture salvarsan, and other German-owned medicinal preparations. Quantity previously sold for $4 now furnished Government at $1.

Made considerable effort to have rank of medical officers made commensurate with the service which the nation expects from the profession.

MEDICAL SCHOOLS.

Urged students to continue medical education so that upon entering government service they might be fully trained; also urged students to apply for commissions in Medical Reserve Corps upon graduation.

Urged schools to release teachers for enrollment in Medical Reserve Corps.

Asked heads of educational institutions to advise pre-medical students to enroll in medical schools of their choice as soon as possible.

Asked medical schools to allow fourth-year students to substitute senior year in base hospital instead of school, if emergency arises.

MEDICAL WAR MANUALS.

Published four war manuals: 1, "Sanitation for Medical Officers," by Edward B. Vedder, M.D., Lieut. Col., M.C.,U.S.A.; 2, "Notes for Army Medical Officers," by T. H. Goodwin, Lieut. Col., R.A.M.C.; 3, "Military Ophthalmic Surgery," by Allen Greenwood, Major, M. R. C., G. E. de Schweinitz, Major, M.R.C., and Walter R. Parker, Major, M.R.C., and 4, "Military Orthopedic Surgery," by the Orthopedic Council.

These also are ready for publication: "Surgery of the Zone of Advance," by George de Tarnowsky, Major, M.R.C.; "Notes on Military Surgery," by George W. Crile, Major, M.R.C., and "Lessons from the Enemy," by John McDill.

NURSING.

Instrumental in increasing by 20 per cent number of pupil nurses in training schools, by means of correspondence with college and school graduates, deans of women's colleges, school principals and Board of Education secretaries.

Distributed about 100,000 bulletins and leaflets for information of prospective students.

Made nation-wide survey of country's nursing resources, and urged heads of training schools and hospitals to increase their facilities.

Published series of twelve articles on nursing in newspapers throughout the country.

Instrumental in having nurses included in War Risk Insurance Law.

Secured evidence of need for military rank for nurses, and secured indorsements of this movement from many persons.

Conducted campaign for increasing number of candidates for nursing education.

Co-operated in preparing details of preparatory nursing course for college graduates at Vassar College.

Recommended to Surgeon General of the Army that increased accommodations for nurses be made at camps, that not less than one nurse be provided to six acutely ill men, that there be a reserve of not less than twenty-five nurses at each camp hospital, and that a qualified nurse tour military and naval hospitals to make observations; all of which recommendations have been favorably received. Miss Annie W. Goodrich appointed Inspector General of Nursing Service in all military hospitals in the United States and France.

Recommended to superintendents of training schools to speed instruction and hold final examinations and graduations early in 1918, and release graduates for government service.

Co-operated with Red Cross and with National Organization for Public Health Nursing in enrollment of public health nurses in office of Red Cross, and urged public health nursing agencies to release staff members for service in extra-cantonment zones and for rehabilitation work in France and Belgium.

Co-operated with Food Administration in having public health nurses instructed in preparation of war-time food substitutes.

RE-EDUCATION AND REHABILITATION.

Presented to Secretary of War plan for formation of Reconstruction Board, including representatives of Army, Navy, Public Health Service, Red Cross, Council of National Defense, Hospitals and Laboratories, Medicine and Surgery, Vocational Education, Labor and Industry. Secretary of War instructed Surgeon General to call conference and formulate plan. As a result bill was drafted providing for vocational rehabilitation and return to civil employment of soldiers and sailors disabled in line of duty.

RESEARCH.

Instituted investigation of conditions under which canned foods become deleterious.

Was instrumental in having University of Minnesota grow a supply of digitalis adequate for America's needs, to replace supply hitherto obtained from Germany.

Instituted tests of devices aimed to protect the ear from injuries by explosives.

Examined and card-indexed numerous antiseptics and disinfectants, furnishing all information to Medical Supply Department of the Army. Valuable cocaine substitutes and cheap disinfectants found usable. Silenced claims of vendors of large number of absolutely worthless preparations.

Placed subject of shell shock in hands of Dr. George W. Crile for study.

Instrumental in bringing into use several substitutes for ambrine, for treatment of burns.

Instituted study which led to discovery that various preparations of thomboplastin help prolong period for coagulation of blood.

Investigated various devices for preparations for sterilizing wounds and germ carriers.

Instituted study of processes for sterilizing drinking water which led to authoritative statement that use of chlorine is best means, chlorine now being used under all conditions.

Instrumental in having prepared authoritative review of war literature bearing upon injuries of the peripheral nerves.

Abstracted all obtainable literature on methods of destroying lice, and instituted experimental research.

Instrumental in having published crit-

ical review of methods and results of vaccination for small pox.

Obtained from a noted French authority statement of results obtained by French investigators as to value of Widal test after vaccination for typhoid fever.

STANDARDIZATION.

Held frequent conferences to study means by which production might be speeded, and demand for diverse types of appliances might be curtailed.

Conferences participated in by representatives of Army, Navy, Red Cross, Public Health Service, and manufacturers of surgical instruments and supplies. Result: Substantial increase in production of staple articles, standardization in types and issuance of four catalogues of staple medical and surgical instruments and supplies for use of Army, Navy and Red Cross.

STATES ACTIVITIES.

Obtained through State and County Committees names of physicians (*a*) available for service in the Medical Reserve Corps, (*b*) those not available because of physical disability, over-age (55), or because of home community need.

Requested co-operation of medical profession in asking aid of Senators and Congressmen for legislation in reference to advanced rank for medical officers.

Made survey of medical schools, as a result of which arrangements were made for enlistment of medical students of well-recognized schools in enlisted medical reserve corps and placing them on inactive list until completion of their medical education. Similar effort made in aid of pre-medical students.

Organized Volunteer Medical Service Corps for physicians ineligible to Medical Reserve Corps, because of physical disability, over-age, or essential home community need.

Prepared and mailed monthly to State and County Committees percentage tables of recommendations by Surgeon General for commissions in Medical Reserve Corps.

Co-operated with Provost Marshal General's office in selecting members of Medical Reserve Corps as medical aides to governors. Formulated outline of duties of medical aides.

Co-operated in having representatives sent to 44 states urging membership in Medical Reserve Corps.

Classified membership records of Medical Reserve Corps from code cards, a set being furnished for the Surgeon General's office in Washington and a set for the representative of the Surgeon General with General Pershing's army in France.

Made survey, through a sub-committee, of ophthalmologists of country, and requested those not needed for institutional and civic needs to join M. R. C.

Same committee standardized methods of eye examinations. Held conference on re-education of blind soldiers, and conducted survey of workshops for the blind.

Made survey and classified, through a sub-committee, the otolaryngologists of country (brain, oral and plastic surgeons), requesting those available to join Medical Reserve Corps.

Recommended that specialists in head surgery be assigned to special duty in military hospitals; also that special hospitals be assigned for treatment of eye, ear, nose and throat cases; also recommended definite number of surgeons and assistants of each specialty, for chief hospitals and for each military division.

WOMEN PHYSICIANS.

Prepared index and complete data as to all women physicians in the United States.

Prepared lists of anesthetists, laboratory workers, radiographers, sanitarians, specialists, and industrial surgeons, willing to serve.

Compiled data regarding recent graduates of 35 coeducational medical colleges.

Secured registration of 1,875 women physicians willing to serve—more than one-third of the total number in the United States.

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There are forty-three American women doctors in foreign medical service at this time.

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

ASSOCIATE EDITORS — C. W. REYNOLDS, C. C. GODDARD, P. S. MITCHELL, O. P. DAVIS, J. J. BROWNLEE, E. S. EDGERTON, K. P. MASON, H. N. MOSES, C. S. KENNEY, D. R. STONER, J. A. DILLON, E. M. CARTER.

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Don't Wait to Be Asked.

Kansas will be called upon for at least one hundred more medical officers. Of course there is no question that that many and more will be furnished if needed. A new plan is to be followed, however, in selecting men for commissions. A record of every physician in the state is or will be in the hands of a committee who will select those who are qualified and can best be spared from civilian practice. These men will be invited to apply for commission. Any reason advanced for not doing so will be carefully investigated. A second invitation will suggest that the excuses are not regarded as sufficient. In some cases is may be necessary to make a more direct and personal appeal. It is safe to predict that the majority of those selected for the honor of a commission will accept without any further appeals from the committee.

If one can judge by the expressions of many of the younger men who were in attendance at the Kansas City meeting, the quota for this state will have been supplied long before the committee gets started in its work.

The Annual Meeting.

The fifty-second annual meeting of the Kansas Medical Society was a very pleasing surprise to all of us.

It was natural to suppose that, with so many of the most active members serving with the army, this meeting would fall far short of the average both in attendance and interest. While we have not the registration figures at hand, we are quite sure the attendance was remarkably good. There was more than the usual amount of interest shown in the program, which certainly merited attention.

Following the custom established at the Topeka meeting, Thursday was set aside for a special program, and on this occasion was very appropriately designated War Day. The program was mostly made up of addresses concerning subjects connected with the war. Dr. Richter and Dr. Neff each gave very interesting reports of their work in base hospitals and the conclusions that had been reached in regard to the treatment of war injuries. Dr. Jabez Jackson made a very eloquent appeal to the profession on behalf of the country in its present great need for medical officers. Col. Bispham described the character of the work in the Medical Officers' Training Camp and the peculiarities in men which tend to make good officers. The addresses of Dr. Robinson and Dr. Sachs, both from Washington University, were interesting and instructive.

The attending physicians were given a sumptuous banquet by the Wyandotte County Society in the dining room of the Scottish Rite Temple on Thursday evening.

The House of Delegates which convened at 8:30 Friday morning was as large as usual and the election of officers was carried on with very little loss of time. Dr. W. S. Lindsay of Topeka was elected president for the ensuing year. Dr. Lindsey has been a member of the Society for a great many years and served as its secretary for several terms. We may safely anticipate his very active interest in its growth and prosperity.

Several invitations were extended for the next meeting, but the Council finally decided upon Ottawa as the next meeting

place. It is understood that a large new hotel will be completed by that time and accommodations will be ample.

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For Senator—Who?

Present conditions are not conducive to a careful analysis of political issues, nor to a proper consideration of the personal qualifications of the various aspirants for political preferment. The attention of every man in the medical profession, who is not in active military service, is now divided between his onerous duties in the care of the sick and those duties of citizenship in times of war which appeal as strongly to the medical profession as to any other class of men.

But one of our duties of citizenship, so likely to be neglected in such turbulent times, calls to us now. More than eighteen thousand of our number are already in active service and at least half as many more will soon be called. Upon these men lies one of the greatest responsibilities of the war and it is a part of our obligation, as members of the medical profession and citizens of the United States, to do all in our power to give them unrestricted opportunity to perform to the best of their ability the functions for which they have been called into the service. Legislation to this end has long been pending in Congress, and when changes are to be made in the personnel of the House or Senate it is well for us to bear in mind these questions now under consideration. Every man in the medical profession knows how important the issue is, how important it is that authority, only conferred by rank, to do and have done those things upon which the health of the army depends, should lie with the Medical Department.

The average voter does not realize how important it is, but we as physicians are in a position to enlighten him, and it is our duty to see that every voter understands and appreciates this issue.

One of the aspirants for the honor of being a United States Senator from Kansas is one of the leading newspaper publishers in the state, the owner and publisher of the most important political organ in the state, but, unfortunately, one whose attitude toward the medical profession has never been very friendly. Nor have its prompt and voluntary response to the nation's call, the sacrifices it has made and the wonderful work it has accomplished received a word of commendation in his paper.

Under date of February 8, 1918, the following appeared in the Daily Capital:

"Whatever may be said of Secretary Baker's stubborn opposition to business war organization, Kansas will feel grateful to him for ordering a review of the trial of Lieut. Dwyer of the Medical Corps at Camp Funston, and for ventilating the conditions that have prevailed at this camp.

"While Lieut. Dwyer was dismissed from the service because of his cruelty in ordering to double duty a sick soldier, Private Gherring, who was brought to him for hospital treatment, having been placed on sick report by his company commander and being so weak that he had to be escorted by a comrade to Dwyer's office, no other punishment was inflicted and no notice given to the conduct of his fellow medical officers. This officer was at the time surgeon of the regimental infirmary. Two or three days later Gherring died.

"It is not the inhumanity of Dwyer that is of first importance, but the fact, admitted by the War Department and affirmed by Judge Advocate General Ansell, in his special report to the Department on the case, that the entire medical staff at Camp Funston, so far as called upon to testify, defended Dwyer's action, attempted to camouflage the inhumanity of his conduct and showed so slight a sense of moral responsibility in this matter that it is regarded as a scandal to the national service.

"By the order of the Secretary of War this trial is to be reviewed and the facts more thoroughly investigated than was done at the original trial. It is fortunate that so early in the war the Department has set up before the medical officers a high standard of fidelity to their duties. At Funston the record indicates that the Medical Corps held together to shield their guilty member, lacking the courage to condemn his conduct or to stand out against the professional conspiracy of side-stepping reticence."

We will ask you what you would expect

the attitude to be of one who would circulate such an article as that, upon questions of particular interest to the medical profession, even though those issues might be of momentous concern to the country. We will ask you, for instance, if in your judgment he would be likely to support the Owen bill. The success of the Owen bill is a matter of great importance to the medical profession of the United States only in so far as it will enable the Medical Department of the Army to render without hindrance the greatest possible service to the sick and injured, and in this respect it is of as great importance to the public at large.

Write to your congressman and your senators and ask them to give their hearty support to the Owen bill. Before you cast your vote for a congressman or senator, find out if possible his attitude toward this bill.

Allowance for Quarters for Officers' Families.

Medical officers will certainly appreciate the recent legislation which provides that commutation for quarters and for heat and light shall be allowed at the point where officers maintain quarters for their families. The enactment reads as follows:

(PUBLIC—NO. 129—65TH CONGRESS.)
(S. 3863.)

An Act to provide quarters or commutation thereof to commissioned officers in certain cases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that during the present emergency every commissioned officer of the Army of the United States on duty in the field, or on active duty without the territorial jurisdiction of the United States, who maintains a place of abode for a wife, child, or dependent parent, shall be furnished at the place where he maintains such place of abode, without regard to personal quarters furnished him elsewhere, the number of rooms prescribed by the Act of March 2, 1907 (Thirty-fourth Statutes, page 1169), to be occupied by, and only so long as occupied by, said wife, child, or dependent parent; and in case such quarters are not available every such commissioned officer shall be paid commutation thereof and commutation for heat and light at the rate authorized by law in cases where public quarters are not available; but nothing in this Act shall be so construed as to reduce the allowances now authorized by law for any person in the Army.

"Approved, April 16, 1918."

An Invitation.

The Chicago Medical Society wishes to invite the physicians of the army and navy and the examining boards of the various states, as their guests during the meeting of the A.M.A. Headquarters will be "Parlor A," La Salle Hotel.

We can assure you it will afford the Medical Society much pleasure to have the physicians engaged in the service visit Chicago during this meeting and will spare no means to make their visit pleasant.

W. T. MEFFORD
JOHN S. NAGEL
J. V. FOWLER
Entertainment Committee.

A Tribute to the Profession.

It may be interesting to the readers of your journal to know my very pleasing experience while serving as a member of a soliciting committee on Liberty Bonds. We were received most cordially by every member of the medical profession we called on (a large number already commissioned in the reserve corps, awaiting call), and having had business dealings with local doctors for the last ten years, my territory was confined principally to localities of down-town physicians' offices.

It was evident in three-fourths of the cases that the subscribers to the Third Liberty Bonds were making real sacrifices, not alone putting their surplus savings into this loan to help the cause, but were eliminating various expenditures and so-called necessities in order to increase their loan to the Government. Considering all this as well as the fact that over twenty per cent of our local profession is now serving either actively or in the reserves,

I will say that the Doctor is doing his "bit."

ALLAN J. HUGHES
Manager Physicians' Supply Co.

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Circular Letter to Physicians.

It is important for the protection of the health of the troops in camps that every community, no matter how small, report the presence of all communicable diseases, especially if present in epidemic proportions. Selected and enlisted men in traveling may be exposed to such diseases and carry them into camp.

It is obvious that disease reporting depends primarily upon the doctors. In this great war thousands of doctors have joined the colors. Surely those who have not could serve their country in this respect by reporting at once all cases of communicable diseases occurring in their practice to the proper health authorities. Where the emergency seems to warrant such action the reports should be made by telephone or telegraph.

In cases of communicable diseases where a selected or enlisted man has been so exposed as to be a serious menace to the camp or post to which he is about to go, it is especially desirable that the attending physician take immediate action to prevent such menace.

For this purpose the following plan of action is suggested by the United States Public Health Service after a conference with Army sanitary authorities:

1. The physician should make an immediate report to the local health authorities who should notify (by telephone or telegraph if necessary) the Senior Medical Officer of the camp or post to which the selected man or soldier may become a menace. A duplicate notification should be made by the local authorities to the state health authorities.

2. If there be no local health authority having jurisdiction, the physician should notify (by telephone or telegraph if necessary) the state health officer, who should notify (by telephone or telegraph if necessary) the Senior Medical Officer of the camp or post to which the selected man or soldier is about to go.

3. The notification should be explicit, giving name of selected man or soldier and other identification data together with his address and the nature of the disease.

4. The notification of the Senior Medical Officer of the camp or post by the local or state health authorities should be in addition to the present procedure in such cases.

RUPERT BLUE, Surgeon General.

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Stand Behind the Boys.

How many doctors have applied this now very expressive phrase to themselves? There is nothing that puts more heart and gives so much confidence to a soldier in the thick of a fight, than the thought that if he does suffer a casualty, he will receive proper medical care and attention. What are you doing in this respect?

There are many boys, sons of your patients or friends, who have been or will be called into the service, and what a source of consolation it would be to the parents to know that possibly their own doctor might be the one to look after their boy and they will welcome your acceptance of a commission in the Medical Reserve Corps and compliment you for so doing.

The opportunity for you to do the most good in a professional way to the greatest number of people, is to offer your service to your country through the Medical Reserve Corps. Do not think longer about it, but apply at once to your nearest medical examining board, and if you are not informed of its locality, the editor of this journal will supply the necessary information.

Stand by our boys, your boys, their boys. Remember the gallant French in '76. The British who stood by Dewey in 1898. The Garibaldis who were always for Liberty.

The rapid expansion of the army calls for a largely expanded Medical Reserve Corps. The Surgeon General has issued a most earnest appeal for doctors. The Department has reached the limit of medical officers available for assignment.

An Imperative Appeal for Medical Officers.

An urgent and imperative appeal has just been issued by the Surgeon General of the United States Army, for doctors for the Medical Reserve Corps.

There are today 15,174 officers of the Medical Reserve Corps on active duty and the Medical Department has reached the limit of medical officers at the present time available for assignment. With these facts before the medical profession of this country, we believe that every doctor who is physically qualified for service between the ages of 21 and 55 years, will come forward now and apply for a commission in the Medical Reserve Corps.

The Surgeon General says: "So far the United States has been involved only in the preparatory phase of this war. We are now about to enter upon the active or fighting phase, which will make enormous demands upon the resources of the country." The conservation of these resources, especially that of man power, depends entirely upon an adequate medical service.

Drafts of men will continually follow drafts, each of which will require its proportionate number of medical officers and there are at this time on the available list of the Medical Reserve Corps an insufficient number to meet the demands of these drafts.

The real necessity for the complete mobilization of the entire profession is imperative. It is not a question of a few hundred men volunteering for service, but of the mobilization of the profession for the conservation of the resources of this country. Let every doctor who reads this editorial and appeal from the Surgeon General, which appeal is based upon dire necessity, act promptly and present his application for a commission in the Medical Reserve Corps at the nearest medical examining board. If you are not informed of the location of your board, the editor of this journal will advise you.

The Chicago Session.

SECTION ON MISCELLANEOUS TOPICS TO CONSIDER REEDUCATION AND REHABILITATION OF DISABLED SOLDIERS.

At its recent meeting the Council on Scientific Assembly arranged for meetings of the Section on Miscellaneous Topics, the subject to be taken up being the reeducation and rehabilitation of the disabled soldiers. Major Frank Billings, head of this division in the Surgeon General's office, has accepted the chairmanship of the section. The subject is one of great importance, especially to medical men. Further announcement will be made later.

SPECIAL GENERAL MEETING.

In addition to the patriotic meeting which will be held on Thursday evening, June 13, and which will be addressed by men prominent in public affairs, there will also be a general meeting on Wednesday evening, June 12, at which eminent physicians who have been active in the medical military service of our nation and its allies will take part.

SECTION MEETING PLACES.

The tentative arrangements for places of meeting are as follows:

Section on Practice of Medicine—Banquet Room, Hotel Morrison.

Sections on Ophthalmology and on Laryngology, Otology and Rhinology—Grand Ball Room and Red Room, respectively, Hotel La Salle.

Sections on Nervous and Mental Diseases and on Dermatology—Ball Room and English Room, respectively, Blackstone Hotel.

The remaining Sections will be grouped, meeting in the Auditorium Theater, the Auditorium Hotel and the Congress Hotel. The theater will house in its main auditorium, the Section on Surgery, General and Abdominal, and in two smaller halls the Sections on Genito-Urinary Diseases and on Gastro-Enterology and Proctology.

In the Auditorium Hotel, the Ball Room will be the meeting place of the Section on Pathology and Physiology, the Ladies' Parlor the meeting place of the Section on Pharmacology and Therapeutics, and the

Section on Preventive Medicine and Public Health will meet in the banquet hall.

In the Congress Hotel, the Elizabethan Room will be the meeting place of the Section on Orthopedic Surgery and the Gold Room, the Section on Obstetrics, Gynecology and Abdominal Surgery; the Florentine Room, the Section on Diseases of Children, and the Green Room, the Section on Stomatology.

The Hotel Sherman will be the general headquarters where will be housed the Registration Bureau, the Information Bureau, the American Medical Association Branch Post Office, as well as the Scientific and Commercial Exhibits.

In next week's issue the accommodations offered by these and other hotels of Chicago for those who attend the annual session will be announced.—Journal American Medical Association, March 23, 1918.

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The Supreme Court Decision on the Corporate Rights of the American Medical Association.

In 1910 the state's attorney of Cook County (Chicago) was petitioned to institute "quo warranto" proceedings against the American Medical Association on the grounds that the Association's affairs were being conducted illegally in that its officers were elected at annual sessions held outside of the state of Illinois. The state's attorney refused to take action in the matter, and later, the attorney general of the state, who was appealed to, also refused to act. January 5, 1911, mandamus proceedings were begun in the Circuit Court of Cook County, Illinois, to compel the state's attorney to initiate the quo warranto action which he had declined to institute. Until December 20, 1915, the issue was between the parties asking for the "mandamus" and the state's attorney of Cook County, Illinois; the point at issue being the technical one as to whether the state's attorney was compelled to act or had discretionary authority in the matter. The case went through the lower courts and finally was carried to the Supreme Court of Illinois, which in December, 1915, refused to hear arguments on the merits of the cause as it related to the American Medical Association, but ordered the Circuit Court to take up the original quo warranto proceedings designed to raise the question of whether or not Illinois corporations "not for profit" are compelled to hold their elections and conduct their business within the confines of the state. Up to this point the American Medical Association was not technically interested in the controversy; now, however, it became a party in the action. Quo warranto proceedings against the members of the Board of Trustees were instituted in the Circuit Court of Cook County, Illinois, which after trial rendered a decision favorable to the Association. The case was then carried to the Appellate Court of Illinois, which confirmed the decision of the Circuit Court. An appeal was finally made to the Supreme Court of Illinois, which last week (April 16) rendered its decision, settling the question. This decision is entirely satisfactory so far as the Association is concerned. One paragraph of the opinion reads:

"It seems reasonably to follow that if a corporation not organized for pecuniary profit may hold meetings at stated times outside of the State of Illinois, composed of delegates selected by the constituent associations, for the transaction of business of the corporation, it is not unlawful to authorize and provide for the election by said house of delegates of trustees of the corporation. The American Medical Association was organized solely for the purpose of the advancement of medical science. Its purpose was to improve methods for the treatment and prevention of diseases of the human race. Its usefulness for these purposes would be seriously interfered with, if not absolutely destroyed, if it could not provide for the election of trustees from the most efficient men in the association throughout the United States, by delegates selected by the constituent associations from the various States in the Union. Such authority to the house of delegates is conferred by the by-laws

and is not in conflict with or prohibited by the constitution or laws of Illinois relating to corporations not for pecuniary profit."

The decision is important not only to the American Medical Association, but also to all organizations incorporated under the law of Illinois—in fact of any state—governing corporations "not for profit."

BOOKS.

New and Nonofficial Remedies, 1918

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1918. Cloth. Price, postpaid, $1. PP. 452 + 26. Chicago: American Medical Association, 1918.

This Annual should be in the hands of every physician. It lists and describes all those proprietary remedies which the Council on Pharmacy and Chemistry has examined and found worthy of the confidence of the medical profession; that is, articles the composition of which is disclosed, which are exploited truthfully and which give promise of some probable therapeutic value. The description of each article aims to furnish a statement of its therapeutic value and uses, its dosage and method of administration as well as tests for the determination of its identity and quality. Articles of similar composition are grouped together and in most cases each group is accompanied by a general article which compares the members of a group with each other and with the established drugs which they are intended to replace. The description of the individual articles and the general discussions are written by experts and furnish information of a trustworthiness unsurpassed by any other publication. The book is especially valuable to the busy physician who desires a concise and up-to-date discussion of such subjects as digitalis therapy, the newer solutions for wound sterilizations, iron therapy, food for diabetics, the value of sour milk therapy and of the bulgarian bacillus, the use of radium externally and internally, of arsphenamine (salvarsan, ersenobenzol, diarsenol) and neoarsphenamine (neosalvarsan, neodiarsenol), of local anesthetics, and other advances in therapeutics.

In addition to this annual issue of the book, supplements are sent from time to time to purchasers. With this volume for ready reference, the physician will be able to determine which of the proprietary remedies that are brought to his notice deserves serious consideration. At least he will be justified to subject to close scrutiny those which have not met the requirements for acceptance for New and Nonofficial Remedies.

The book is sent postpaid for one dollar. Address the American Medical Association, 535 North Dearborn Street, Chicago.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1917.

Cloth. Price, postpaid, 50 cents. Pp. 169. Chicago: American Medical Association, 1918.

This volume contains the reports of the Council which were adopted and authorized for publication during 1917. It includes reports of the Council previously published in The Journal of the American Medical Association and also reports which, because of their highly technical character or of their lesser importance, were not published in The Journal.

In this volume the Council discusses the articles which were examined and found to be in conflict with the rules for admission to New and Nonofficial Remedies. Among these reports are discussions of such widely advertised proprietaries as Corpora Lutea (soluble extract), Wheeler's Tissue Phosphates, the Russell Emulsion and the Russell Prepared Green Bone, Trimethol, Eskay's Neuro Phosphates, K-Y Lubricating Jelly, Ziratol, Hepatico Tablets, Hemo-Therapin, Venosal, Surgodine and Kalak Water. A report on Iodeol and Iodagol covers 51 pages and illustrates the exhaustive investigation which the Council is often obliged to make of proprietary articles. Similarly illustrative of the Council's thoroughness is the clinical study of Biniodol, a solution of mercuric iodid in oil, and the investigation of Secretin-

Beveridge, made for the Council by the physiologist, Professor Carlson, of the University of Chicago. The volume also contains reports which explain why certain preparations, such as Alcresta Ipecac tablets, the German-made biologic products and antistaphylococcus serum, which were described in the last edition of New and Nonofficial Remedies, are not contained in the current 1918 edition. Those who wish to be informed in regard to proprietary remedies should have both the Annual Council Reports and New and Nonofficial Remedies.

Postgraduate Medicine, Prevention and Treatment of Disease.

By Augustus Caille, M.D., F.A.C.P., Emeritus Professor of Medicine and Consultant to Department of Pediatrics, New York Post-Graduate Medical School and Hospital; Consulting Physician to the German Hospital; Consulting Physician to Isabella Home and Hospital and Sea Cliff Convalescent Home, etc. Profusely illustrated. Cloth, 8-vo, 1,024 pages. Published by D. Appleton & Company, New York and London.

A book dealing mistly with methods of treatment and following, to a large extent, the experience of the author in his many years of practice. A considerable amount of space is given to the technique of office and bedside procedures.

Many prescriptions are given for the remedies and combinations the author has found to be of service in the treatment of various diseases.

While there is very little that is new in this book, the various methods of treatment are concisely stated, and will readily appeal to the busy practitioner. In some instances a little more elaboration of details would have added value to the work.

American Illustrated Medical Dictionary (Dorland).

A new and complete dictionary of terms used in medicine, surgery, dentistry, pharmacy, chemistry, veterinary science, nursing, biology, and kindred branches; with new and elaborate tables. Ninth edition, revised and enlarged. Edited by W. A. Newman Dorland, M.D. Large octavo of 1,179 pages with 331 illustrations, 119 in colors. Containing over 2,000 new terms. Philadelphia and London: W. B. Saunders Company, 1917. Flexible leather, $5 net; thumb index, $5.50 net.

To those who are familiar with Dorland's Dictionary, it is necessary to say that a new and enlarged edition has been published which contains over 2,000 new words, including those words and abbreviations introduced into medical literature by the war. To those who are not familiar with it, we can frankly say that it is one of the most complete medical dictionaries ever published. In addition to the definition, pronunciation, capitalization and etymology of medical words, it contains complete anatomical tables of the arteries, veins, muscles, and nerves, giving the name, origin, distribution, branches, insertion, function, nerve supply. All recognized signs and symptoms are given with methods of elicitation and significance.

There is a dosage and therapeutic table, a table of exanthemata—giving symptoms, incubation period, site, character and duration of the eruption.

Descriptions of all the serums are given, with indications for use. All the laboratory and clinical tests are described, as are all the reactions, staining and fixing methods.

Many other interesting features might be mentioned, but it is sufficient to say that nothing seems to have been omitted that could be of any possible value.

A Text-Bbook of the Practice of Medicine.

By James M. Anders, M.D., Ph.D., LL.D., Professor of Medicine and Clinical Medicine, Medico-Chirurgical College Graduate School, University of Pennsylvania. Thirteenth edition thoroughly revised with the assistance of John H. Musser, Jr., M.D., Associate in Medicine, University of Pennsylvania. Octavo of 1,259 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $6 net; half morocco, $7.50 net.

This is a thoroughly revised edition in which much new material has been added, and some of the subjects carefully rewritten. New matter has been added on treatment of tetanis, acidosis, chylothorax, on etiology of aortic incompetency, treatment of asthma, diverticulitis, functional tests of hepatic insufficiency, Gaucher's disease, estimation of renal function, anaphylaxis of food intoxication, the pneumococcic infections, focal sepsis, rat-bite feber, febris wolhynica, and pyorrhea alveolaris. All of those subjects upon which recent investigations have given new light, have been rewritten.

It is unnecessary to comment on this

work. Ander's Practice of Medicine has long been recognized as one of the standard text-books in medicine.

No one can have too many books in the practice of medicine, but certainly no one will have enough who has not an Anders.

Clinical Lectures on Infant Feeding.

By Lewis W. Hill, M.D., Children's Hospital, Boston, and Jesse R. Gerstley, M.D., Michael Reese Hospital, Chicago. 12-mo of 377 pages illustrated. Philadelphia and London: W. B. Saunders Company. 1917. Cloth, $2.75 net.

This is two separate and distinct series of clinical lectures on infant feeding—the lectures by Dr. Hill, covering the Boston methods, and those by Dr. Gerstley, the Chicago methods. Both series of lectures were given by the authors as a post-graduate course to the physicians of North Carolina, but in different parts of the state. While the same ground is covered by both, they are so dissimilar, more particularly in the presentation, that one does not feel that he is going over the same ground in reading both of them. They are certainly well worth reading.

Infant Feeding.

By Clifford G. Grulee, A.M., M.D., Assistant Professor of Pediatrics at Rush Medical College; Attending Pediatrician to Presbyterian Hospital, Chicago. Third edition thoroughly revised. Octavo of 326 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $3.25 net.

The third edition of Grulee's Infant Feeding has been revised to cover the progress which has been made during the past few years. This progress has been particularly notable in Pediatrics. A more careful study of the metabolism of nutrition has given many valuable suggestions for the proper feeding of infants, and to all of these matters the author has given careful consideration. The chapter on absorption and metabolism has been revised and elaborated. This is one of the real scientific works on infant feeding.

MISCELLANEOUS.

Entrance Conditions in Medical Schools.

One of the problems which has lately come uppermost in dealing with medical schools is that relating to entrance conditions. The various phases of this problem are discussed in an article by Dr. Harley E. French, published in this issue of the Journal. Two state licensing boards recently have adopted rules absolutely prohibiting the admission of students with conditions. This rule is an extreme reaction against the practice in former years of a considerable number of medical colleges—and of a much smaller number at present—of admitting students with an overabundance of conditions. To adopt so extreme a measure, however, in an effort to regulate a few medical colleges which are unwilling voluntarily to enforce reasonable entrance requirements, would seriously interfere with the administration of requirements for admission in a large majority of the medical schools which are conscientiously enforcing them. As with any other regulation applying to medical schools, the rule relating to conditions should not be so rigid as to prevent the entrance examiners of our high grade medical schools—who, after all, are the highest authorities on this question—from dealing wisely with each individual student who applies for admission. As a matter of fact, certain students may meet the technical requirements of the rule who are not mentally qualified to take up the study of medicine. These would be accepted by the low-standard colleges, but would be rejected by the examiners of our leading medical schools. On the other hand, in the experience of medical deans, there are many students who have had more than the minimum amount of training required, who are mature and, in fact, are fully equipped mentally to enter on the study of medicine but who lack a portion of the technical requirements specified in the rule. The latter, with conditions, will undoubtedly make better medical students than the former without conditions. Meanwhile, the decision as to whether conditions are to be allowed or not is necessarily a part of the problem of administering entrance requirements and should be left to those who are expert in that work. Given an experienced and intelligent en-

trance examiner—an essential of every approved educational institution — and he should be left free to administer the details of entrance qualifications, even to the allowing of conditions where that appears to be justified. Should the privilege be abused, the fact would soon be discovered by standardizing agencies, which could then withdraw their approval from the college until such abuses were corrected. All rules governing medical education which are worth while have emanated from the better grade of our teaching institutions. Any rule, therefore—including the rule in regard to conditions—which would prevent such action as our leading educational institutions may find desirable, would prevent the further development of educational ideals and methods.—Journal A.M.A., April 13, 1918.

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The Van Slyke Test for Acidosis.

A simple test for acidosis which has been found to be trustworthy in diabetes has been devised by Van Slyke, who is making notable researches in biological chemistry in the Rockefeller Institute for Medical Research. He finds that the sum of the total acidity and ammonia of the urine expressed in c.c. of decinormal solution, give an accurate measure, the milder stages of acidosis in diabetes. In other ailments he has not found this method so satisfactory. Comparisons of the results of this procedure with those obtained from analysis of the blood show that in severe acidosis the results are not quite so trustworthy as in the less pronounced forms. Analysis of the blood is the most accurate of all the methods of determining acidosis, but requires equipment and labor which are not to be had in the ordinary laboratory which is at the service of the physician. Van Slyke, after experimenting with various other tests for acidosis, recommends the one devised by him—when the patient is suffering from diabetes. He has prepared a table for determining the degree of acidosis. The body weight is divided by the number of c.c. of decinormal solution. From 0 to 12 c.c. per pound is normal; 12 to 30, indicated mild acidosis; 30 to 45, moderately severe, and above 45, severe.

The Battle Creek Sanitarium has recently adopted the Van Slyke method with advantageous results.

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Trial Tubes of Chlorazene.

It is interesting to learn that the Abbott Laboratories of Chicago are sending to physicians, on request, convenient trial tubes of ten Chlorazene tablets. In view of the growing importance of the Dakin discoveries, we suggest to our readers that they avail themselves of this generous offer.

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Chloretone: Suggestions for Dosage.

For its hypnotic effect Chloretone may be administered in doses sufficient to produce the desired result without endangering the life of the patient. As one writer points out, it is useless to expect to attain that end by giving the patient small doses — five grains — at long intervals — three times daily. In general, a single dose of five to twenty grains will have the best effect. It would be well to give about ten grains the first night, fifteen the second, and twenty grains the third. When a dose is found that produces the desired result, the same dose may be repeated until the "sleep habit" has become established, when it should be reduced gradually.

When the use of Chloretone must be continued for a protracted period, as in the treatment of epilepsy, its effects should be watched lest a cumulative action manifest itself. It should not be pushed to the point of dullness and drowsiness.

As a sedative in asthma, chorea, pertussis, nausea, emesis gravidarum, and seasickness, doses of three to ten grains, at stated intervals according to the effect, are generally sufficient. As a preventive of post-anesthetic nausea the administration of ether is the usual practice.

The principal effects of Chloretone are manifested upon the central nervous sys-

tem. It acts like other hypnotics, but, unlike most of the latter, it does not depress the circulatory system, nor does it disturb digestion.

Chloretone is procurable in three-grain and five-grain capsules, convenient for administration.

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Colorimetric Determination of the Reaction of Fluids.

G. D. Barnett and H. S. Chapman, San Francisco (Journal A. M. A., April 13, 1918), describe a method devised to make a fairly accurate determination of hydrogen ion concentration for use of colorimetric methods of determining the reaction of bacteriologic mediums and other fluids. Their method involves only the reactions lying between 7.0 and 8.0 and only phenolsulphonephthalein has been used as an indicator. Use was made of the principle of superimposing the two extreme colors of the indicator as used by Clark and Lubs, following Salm in determining the so-called half-transformation points of indicators. Within the range of its transition from red to yellow, we may regard the observed color of a phenolsulphonephthalein solution as composed of a definite amount of red plus a definite amount of yellow, and such a color may be exactly duplicated by superimposing the extreme red and the extreme yellow of the indicator in proper concentrations. Thus, if to one test tube we add 5 c.c. of dilute acid, and to another similar tube 5 c.c. of alkali (dilute), and to each add 5 drops of phenolsulphonephthalein solution, a bright yellow will be produced in the first tube and a bright red in the other. But if we look toward the light through both tubes, a color will be observed that is half way between the yellow and the red. In fact, it will be identical with the color produced by 10 drops of the phenolsulphonephthalein solution in 5 c.c. of a standard solution having pH of 7.9. This is the half-transformation point, and is a definite constant for this indicator. But if instead of using equal amounts of indicator in each of the two test tubes we vary the partition of the 10 drops of indicator between them, then by superimposing each pair and viewing them by transmitted light, a series of colors will be produced which will cover the range of usefulness of the indicator; and once such a series is "calibrated" against solutions of known hydrogen ion concentration, it may be used as a standard series for the determination of unknown reactions. The results obtained by such a procedure in the case of phenolsulphonephthalein, compared with phosphate solutions, prepared according to Sorensen, are given in tabulated form. The method of preparation and titration is described in detail.

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Trench Nephritis.

The Journal A. M. A., April 6, 1918, publishes an abstract of an article from the Quarterly Journal of Medicine, by two British officers, W. H. Tytler and J. A. Ryle, on trench nephritis as observed in a casualty clearing station, during 1916 and the early part of 1917. The cases numbered 150, and they usually gave a history of onset about three weeks before admission. All cases presented constitutional symptoms, as well as albuminuria. The almost constant complaint was shortness of breath on exertion, while swelling of the limbs and face was also frequently noted. In the early part of the disease the most striking symptoms were pallor edema and dyspnea. The bronchitis, usually present, was undoubtedly the prominent cause of the severe respiratory symptoms. The authors consider the dyspnea primarily due to pulmonary edema, a view confirmed by necropsy findings. Striking resemblance was often noted between the respiratory symptoms in trench nephritis and those seen in cases of gas poisoning. The pulse, in nearly all cases, was full and bounding, and the blood pressure was generally above 140 mm. of mercury. Fever was not usual save in relation to the bronchitis, except in a small group of cases. The presence of albumin and casts in the urine, and the relatively small amount of expectoration distinguished the cases from

those of capillary bronchitis. In spite of the anasarca and the pulmonary edema the amount of urine was not excessive, but below normal. None of the cases with respiratory symptoms and edema showed evidence of uremia. In fatal cases death usually occurred the second week, with increased cyanosis, severe dyspnea, and profuse frothy expectoration. Death in all cases was apparently due to respiratory failure. In all but one there was associated bronchitis. The death ratio was 4 per cent. Early diagnosis was found important. Warmth and rest in bed with good nursing and the administration of saline purgatives produced a rapid change in the less severe cases. Postural treatment of the dyspnea, and oxygen when necessary—given preferably by the continuous intranasal method—gave much relief. In uremic cases bleeding and lumbar puncture may give relief. The urine nearly always showed a large amount of albumin on admission. Urea in the blood averaged about 0.08 per cent, and was not in constant relation with the urea in the urine. There were twenty-five necropsies made, and the most constant gross changes observed were those seen in the lungs and spleen, consisting, briefly, in an extensive pulmonary edema, and characteristic splenic hemorrhages. The kidneys constantly showed to the naked eye only the most slight and indefinite changes. The only changes suggesting disease was a slight pallor and opacity of the cortical tissue. Bacteriologic examination was carried on, both in living and fatal cases. The findings apparently were not very definitely characteristic, as a rule. In a series of forty cases cultures were made from the urine and in twenty-four of them the urine showed streptococci of the enterococcus type, which are described. In most cases the hemolytic streptococci were also present. Cultures from the beart-blood remained sterile in sixteen out of a number of control cases. But in none of the control cases was an enterococcus found in cultures from the throat.

The Pneumonias.

J. G. Cumming, Ann Arbor, Mich., C. B. Spruit, Boston, and Charles Lynch, Fort Sam Houston, San Antonio, Texas (Journal A. M. A., April 13, 1918), report on the pneumonia situation in Fort Sam Houstin and Camp Travis, Texas. In following out the plan of determining the prevalence of type pneumococci and hemolytic streptococci in all cases of measles and to ascertain how many were carriers of these organisms, 291 swab cultures were made. "Of these, 187 showed Types I and II hemolysis. Among these patients, twenty-five, or 13 per cent, developed complications as follows: otitis media, 5; bronchopneumonia, 4; tonsillitis, 4; scarlet fever, 3; lobar pneumonia, 2; mumps, 2; arthritis, 1; sinusitis, 1; acute bronchitis, 1; erysipelas, 1; cellulitis, 1; abscess of gum, 1. Among these twenty-five patients there were twenty-six complications. During the bronchopneumonia complication in the four cases referred to in this group, Type III hemolytic streptococci were isolated." Of the total swab cultures, 104 showed Type III hemolysis, and among these, fifty-one developed complications. Among the fifty-one patients there were fifty-seven complications—altogether numbering fifty-seven different conditions—bronchopneumonia, empyema, tonsillitis, arthritis, etc., some of which may have been merely incidental to the measles infection. If only the pneumonia cases are considered in these two groups of throat findings, it will be noted that among those patients from whom Types I and II were isolated, only 3 per cent developed pneumonia; while among those harboring Type III hemolytic streptococcus 33 per cent developed pneumonia. Whether the same proportion would be found in the civilian population, the authors do not venture to say. Seventy swabs from average throats showed only 6 per cent hemolytic streptococci, and they ask, how is this low percentage to be accounted for, and is it possible that the streptococcus in the throat prepares the way for measles virus infection, which in turn prepares the way for

streptococcus pneumonia, and an extension of this infection elsewhere, and is this supposition applicable to scarlet fever and its complications? They divide the ward into three sections, the first is called the detention section, and in this section the sheet method is used to protect the patients. Of patients with pneumonia following measles, twenty-eight blood specimens in all were tested, and four, or 17 per cent, were found positive for hemolytic streptococci. These results are shown in tabulated form, as well as the bacteriologic findings in pleural exudates and at necropsy. It would seem that the hemolytic streptococcus was the cause of death in twenty-nine out of thirty-one necropsies, lobar pneumonia cases included. Assuming that universal vaccination against the predominant type, or types, of the hemolytic streptococcus will protect against infection, the mortality of the pneumonias should be greatly reduced. The importance of taking both swab and sputum specimens was emphasized by their findings. On account of the prevalence of streptococcus pneumonia, the authors state that it is apparent that a new differential procedure for type identification is required. They point out the difficulties of the mouse and Avery methods, and say that a new method of procedure must be devised which includes the identification of the hemolytic streptococcus, and they offer a method for this purpose, which is not technically difficult, they claim, and is reliable. As regards vaccination and the serum treatment, the following points must be considered: (*a*) The advisability of vaccinating by the intravenous route all measles patients that are found to be hemolytic streptococcus carriers; (*b*) the possibility of developing in the horse a high titer antihemolytic streptococcus serum for preventive as well as curative purposes. (*c*) Since approximately 60 per cent of pneumonias are type epidemic varieties, and at least a large percentage of the remainder hemolytic streptococcus pneumonias, the advisability of carrying out universal vaccination of troops by combining Types I and II pneumonias with the hemolytic streptococcus. The authors hold that pneumococcus pneumonias are not in and of themselves as fatal as has been believed. According to their findings the hemolytic streptococcus was found to be the immediate cause of death in 77 per cent of the cases. Experiments in animals are more conclusive in demonstrating protection against both streptococcus and pneumococcus infections than they are against the typhoid conditions, and they suggest that a triple vaccine consisting of the hemolytic streptococcus and pneumococci Types I and II, would be as effective, in its way, as the typhoid (triple) vaccine, and it should also protect against scarlet fever and its complications.

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Joint Affections.

J. W. Churchman, New Haven, Conn. (Journal A. M. A., April 13, 1918), refers to a former paper on this subject, and says that he has perfected the apparatus and method so that the problem of thorough irrigation and cleansing of a joint cavity is solved. He had formerly shown that gentian violet has a selective bactericidal property, running roughly parallel with the Gram reaction, and he has made other studies of stains closely allied to gentian violet, and found that they have a similar selective action. The apparatus devised consists essentially of a series of interconnecting chambers leading ultimately to a single tube, which is attached to an aspirating needle for insertion into the joint. The detailed description requires the illustrations. By a series of stopcocks the joint is thoroughly washed out and the synovial membrane is cleansed. Besides his experimental work, in which he demonstrated the possibility of gentian violet, he has used the method clinically in the New Haven Hospital, in eight cases of knee joint disease, two of them pyogenic, five gonorrheal, and one probably tuberculous. Two cases in which the effect of the treatment was controlled, not only by clinical observations but also by roentgen ray and bacteriologic studies, are

reported. He is justified, he thinks, in saying that a pyogenic or gonorrheal infection of the knee, may be cured simply and promptly by lavage of the joint and staining with gentian violet. It is probable, of course, that the longer the condition has lasted, the more obstinate will be the disease, and if the bone is involved it cannot be influenced by the treatment. He is inclined to think mere cleansing of the joint is not the cause of the cure, but that the gentian violet plays a part. He has shown elsewhere that it has a bactericidal effect on gram-positive organisms when present in weak dilutions and prevents the growth of gram-negative organisms when used in strong dilutions. He is now working on the treatment of other cavities and abscesses near the surface, and his success has led him to use it by injecting it directly into the tissues. Here he had to proceed with the greatest caution, as there is some danger that necrosis might be produced. Positive conclusions, therefore, cannot be drawn, but he has had encouraging results in one case, at least, of pyorrhea. He is also experimenting with gentian violet in parasitic diseases of the skin, and is hoping for good results.

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Bladder Drainage.

A new technic for bladder drainage is described by H. P. Jack, Hornell, N. Y. (Journal A. M. A., April 27, 1918). It is an adaptation of the use of the Murphy button, one-half of which is inserted into the end of a large rubber tube, the rubber end surrounding the button closely about its shank. The other half of the button, surrounded down to its shank by a soft rubber ring, if desired, so that it will not cut through too quickly, is placed inside the bladder through a small slit. The bladder tissues are brought firmly about the shank of this half of the button, and the two halves are pushed closely together. This gives a perfect joint and enables one to use his drain as much or as little as he pleases. If not satisfied as to the perfect drainage, another and smaller tube may be introduced inside of the larger one, clear to the bottom of the bladder. Forty-eight hours after this operation, which is usually performed under local anesthesia, quinin and urea hydrochlorid, four-hour washings of the bladder are begun. He has used this technic in ten cases of prostatectomy with utmost satisfaction, and it has saved much suffering to the patient. He has never used the rubber ring suggested. The button has always remained in the tissues without cutting, for two weeks. Should it be desired to keep the button in place for a much longer period, the use of the ring is obvious. The incision into the bladder may be of sufficient length to allow search for and removal of stones, which is imperative.

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Polyuria.

Jacob Rosenbloom, Pittsburgh (Journal A. M. A., May 4, 1918), reports a case of diabetes insipidus cured or relieved by treatment with pituitary extract. The condition had been present for nine years and, therefore, was considered cystic rather than malignant. The presence of the hemianopsia revealed the fact that there was pressure on the optic tracts. The sella turcica was normal as shown by the roentgen ray. Thyroid tablets were ineffective.

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Required by the Act of Congress of August 24, 1912, of the Journal of the Kansas Medical Society Published Monthly at Topeka, Kansas, for April 1, 1918.

State of Kansas, County of Shawnee, ss.

Before me, a notary public in and for the state and county aforesaid, personally appeared W. E. McVey, who, having been duly sworn according to law, deposes and says that he is the editor of the Journal of the Kansas Medical Society and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in Section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of	Post Office Address
Publisher—W. E. McVey, under direction of the Council of the Kansas Medical Society	Topeka, Kansas
Editor—W. E. McVey	Topeka, Kansas
Managing Editor—None.	
Business Manager—None.	

2. That the owners are: (Give names and addresses of individual owners, or, if a corporation, give its name and the names and addresses of the stockholders owning or holding 1 per cent or more of the total amount of stock.)

Kansas Medical Society, Dr. Chas. S. Huffman, Topeka, President; Dr. J. F. Hassig, Kansas City, Secretary; Dr. L. H. Munn, Topeka, Treasurer.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only).

W. E. McVey, Editor.

Sworn to and subscribed before me this 27th day of March, 1918.

R. A. Ferlet,
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THE JOURNAL
of The
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Vol. XVIII TOPEKA, KANSAS, JUNE, 1918 No. 6

Treatment of Burns.

GEO. M. SEACAT, M.D., Cherryvale, Kan.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

It is an old and trite saying that "it is an ill wind that blows nobody good"; and while, at first thought, it may be considered brutally cruel to apply this old adage to the tornado of destruction that is now sweeping over and devastating Europe, a moment's consideration will, I think, convince us that it may be aptly so considered. The Great War has stimulated the master minds of the age to the most intense activity — those on the destructive side of humanity to the invention and application of more and still more powerful engines of destruction and slaughter, while on the humane side equally able minds have been and are active in devising new and better methods of preserving the health of the men in the camps and trenches, and of treating those wounded in battle. And I firmly believe that after the dogs of war have been chained, and the discordant and bloody passions of the nations have been swept away, that the achievements in medicine and surgery growing out of the great conflict will descend as blessings of such stupendous magnitude to the human race in the ages to come that we may truthfully say of the besom of destruction that now sweeps Europe: "It is, indeed, an ill wind that blows good to none."

Probably in no part of this great work has more success been achieved than in the treatment of open, infected wounds, and in the treatment of burns.

A perusal of medical literature discloses the fact that almost every drug in the Pharmacopœa has at some time been used in the treatment of burns. There are countless ointments, mixtures and methods in use today, all having enthusiastic exponents for their particular efficacy.

Previous to the discovery of antiseptics, and for some time afterwards, carron oil was the agent of choice. The difficulty of keeping carron oil aseptic has caused it to be generally discarded for picric acid, normal saline, and the open method, with dusting powders of sterate of zinc and boric acid.

Nine years ago Dr. Sherman and his associates in the surgical department of the Carnegie Steel Company attempted to standardize, as nearly as possible, the treatment of burns. At that time there were many conflicting opinions, and it was with difficulty, requiring much persistence and persuasion, that they were able to reduce the choice in the number of agents of treatment from eighteen to four, viz: picric acid, normal saline, boric acid ointment or solution, and the open method, with boric acid.

The same general confusion and misunderstanding exists today throughout the profession in the treatment of burns. There has never been any attempt at standardization, because there was little to choose from among the various methods, none of them being satisfactory, and all leaving much to be desired from the standpoint of both patient and physician. Notwithstanding this state of affairs, the

general concensus of opinion was that "We get good results." The natural question is, "What are good results, and upon what should our standards be based?"

Needless to say the method which best relieves pain and at the same time promotes rapid healing, with a minimum of cicatricial tissue, is the method of choice.

During the past seven years Dr. Sherman and his associates have treated more than 33,000 burns of the first and second degrees, and more than 5,000 of the third degree. They have thoroughly and scientifically tried every known method. For the ambulatory cases boric ointment and picric acid, in 0.9 per cent solution, seemed to give the same results. The hospital cases were treated by the "open method," with the use of dusting powders, followed by dry heat and boric ointment, and so forth, as this method seemed to cause the least pain and discomfort to the patient. The continuous bath treatment offered no special advantages, and was found difficult to carry out when there are a large number of persons to be treated.

One of the basic principles in the treatment of burns has been to exclude the air. This cardinal factor has been well known for centuries. Notwithstanding this recognized principle, not until Barthe de Sandfordt perfected a mixture of paraffin, beeswax and resin were we furnished with a satisfactory dressing which actually excluded the air.

Sixteen years ago, as a railroad surgeon in China, Sandfordt first used paraffin wax in the treatment of burns. The results were so satisfactory that he continued to experiment in the use of this agent, and to improve it, until finally a combination of paraffin, beeswax and resin was perfected and placed on the market under the trade name of "Ambrine." Five years ago attempts were made to market this product and to introduce the treatment in the United States. They met with failure. First, because the principles advanced were contrary to previous ideas, theories and practices. Second, the treatment was advocated for conditions where it was of questionable value. And third, because it was a patented preparation. The attempt to popularize the method in France and the United States met with medical opposition and financial failure for its author. Sandfordt was looked upon as a crank, and in general the method fell into disrepute. It was not until the present war that Sandfordt was given an opportunity to treat a large series of cases, and prove the merits of the method. Dr. Sherman says: "It was not without misgivings and doubts that I visited the hospital at Issy-Les-Moulineaux, where de Sandfordt was treating a great many burns of all degrees. However, the results obtained were self-evident, and spoke eloquently of the new method, and it was not difficult to give up former theories and ideas. There was no alternative."

To seal up an infected burn was thought to be contrary to all sound surgical principles. Notwithstanding this, the patients were being dressed without pain, they were recovering two to three times more rapidly than under former methods, and free from cicatricial contraction, and with a minimum of scar tissue. It must not be assumed that all third and fourth degree burns heal without any scar tissue formation. There is some scar tissue, but it is much less than with other methods, and does not have the tendency to contract, so that the frightful disfigurements and loss of function are practically eliminated.

In the majority of cases the patient is free from pain after the first twenty-four hours. This one factor alone justifies its use.

This method is now used to the exclusion of all others in all of the emergency hospitals of the United States Steel Corporation, with the most gratifying results. The men have learned, from the experience of their fellow workmen, the superiority of the paraffin treatment, and insist upon its use.

In carrying out the method all burns, of whatever character, are thoroughly dried and an airtight coating of paraffin wax is applied to the burned area and

made to extend over from one-half to one inch onto the adjacent healthy skin. A thin layer of cotton is then applied, which is at once incorporated with the first film of wax by painting with a fine varnish brush sufficient wax to completely impregnate the cotton. The wax "sets" in a few seconds. The dressing is then completed by swathing the entire waxed area with cotton and bandage. All burns are redressed every twenty-four hours. The wax method does not necessarily contain any specific curative medicinal ingredients, but acts entirely mechanically, allowing nature to heal under conditions favorable to repair. Medicinal ingredients, such as picric acid 0.9 per cent, oil of eucalpytus, and so forth, may be incorporated with the wax, possibly sometimes to advantage. The wax-cotton dressing is a non-adhesive shell which excludes the air, maintaining a constant temperature, and forms a protective dressing to the proliferating tissues under the best physiological conditions, allowing regeneration and restoration along natural lines. The wax serves as a superstructure or scaffolding, and protects the new epithelium, which rapidly regenerates. The dressing serves as a poultice, splinting and holding at rest the traumatized tissues. In a short time secretions form under the dressing, which makes it non-adhesive and easy to remove without pain or bleeding, and without destroying the new regenerated epithelium, thereby facilitating the healing without contracting cicatrices, and without causing deformity or functional disability. Any wax preparation with sufficient pliability and ductility not to crack after it is applied, will give good results.

Ambrine is a neutral paraffin, beeswax and resin combined, prepared according to a secret formula. On account of its organic composition it is impossible to analyze. There are many imitations on the market, including Cerelene, Mulene, Parresine, Redintal, Stanolind, and so forth. Many of these preparations are mere mixtures, while others are especially prepared pharmaceutical products. Of these I have used only Parresine, which I find differs in no way from Ambrine.

METHOD OF APPLICATION.

Adequate apparatus:

One fine varnish brush;
One pan with water, and a glazed bowl;
One drier—a fan of any kind.
Absorbent cotton, divided into very thin layers.

When the patient enters the hospital—or office—the clothing is removed, all blebs are punctured, but not excised, the wax is applied to the burn at the earliest opportunity. If a brush is used the wax should be gently daubed on without pressure. To and fro painting movements are painful, and tend to destroy the delicate granulations.

For the first two or three weeks, or until the granulating area shows a minimum of wound secretion, the dressing should be changed every twenty-four hours, because in the early stages of the wound there is a rapid sloughing and separation of necrotic tissue, and a large amount of lymph which collects under the shell. This sero-purulent liquid gently lifts the wax from the wound, so that it does not adhere to the tissues, and if it is very profuse frequently drains from under the edges of the dressing. The wax shell is readily removed without pain by lifting it from the edges or by making an incision with scissors through the shell and then gently peeling it off, it slips off very readily. The wound will be found to be freely bathed with lymph and a purulent secretion, composed largely of the broken down necrotic tissue, and in the early stages sloughing masses, which at times develop a very offensive odor resembling the odor of fetid feet. This disagreeable effluvium is no contra-indication to the continuance of the treatment. The wound is then gently cleansed with a mild antiseptic solution (saline or boric acid solution—or, I have found hydrogen peroxide to be very efficient, because of the facility with which it dislodges and removes particles of necrotic tissue that may adhere to the

wound). Great care should be taken not to disturb the fine film of epithelium which rapidly starts to grow from the edges of the sound skin. Cotton balls can be used to wipe away the secretions. The entire wound is then thoroughly dried, the granulations taking on a smooth, varnished appearance. The wax is then applied, and the dressing completed as in the first instance.

———R———

Uremic Ulceration of the Intestine.

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Uremic ulceration of the intestine has in the lapse of years gradually come to be recognized as one of the complications of nephritis. Garrod[1] states that "Ulceration of the intestines, although rare, has been met with in a sufficient number of cases to justify its inclusion among uræmic, or perhaps to speak more accurately, among renal accidents." Dieulafoy[2] has called attention to this complication and mentions several observations. Aschoff[3] mentions its occurrence and presents an excellent microscopic picture of the condition. MacCallum[4] states that acute diphtheritic enteritis is a frequent terminal affection in uremia.

In the following case of chronic nephritis with uremia, there was a very extensive diphtheritic enteritis with ulcer formation and perforation of one of the uremic ulcers.

The patient, M. N., a colored woman aged 20, entered the Bell Memorial Hospital May 10, 1917, complaining of shortness of breath. The patient's present illness she dates from five months ago when she began to have dyspnœa upon exertion and noted frequent swelling of both ankles. For the past three months she has coughed a great deal.

Physical examination showed a rapid heart, somewhat irregular pulse 118 to the minute, and numerous moist rales over the lungs especially on the right side. Both ankles were swollen. The white blood count on admission was 16,500. The urine showed a specific gravity of 1010, albumen was present and there were numerous hyaline and granular casts. May 15 the patient complained of intense abdominal pain and on examination the abdomen was found to be markedly distended and very tender on pressure. This abdominal pain and tenderness persisted with increasing severity until death. On May 16 a marked gallop-rhythm of the heart was noted. The patient's abdomen was tapped May 17 and a quantity of cloudy fluid was obtained. The patient was very dull and comatose for the last two days before death, which occurred on May 18, 1917. The temperature on admission was 97.5 degrees but arose to 102 degrees the day of death.

The autopsy was performed one hour and twenty minutes after death. The body is that of a large obese mulatto woman measuring 167 cm. in length. There is a considerable amount of thin foamy fluid running out of the mouth and nostrils. The lower extremities show marked edema.

The abdomen is distended and upon opening it a large amount of slightly turbid fluid escapes, about 3 liters in amount. Both pleural cavities contain approximately 1 liter of clear straw-colored fluid. The pericardium contains 100 cc. of clear fluid. The heart weighs 505 grams and shows a marked hypertrophy of the left ventricle which measures 2.3 cm. in thickness.

The lungs are edematous, the liver shows some chronic passive congestion. The spleen, pancreas, stomach, bladder, uterus and adnexa are apparently normal.

The kidneys are smaller than normal, especially the left. The capsules strip with difficulty leaving a markedly granular surface beneath.

The cortex of both kidneys is markedly thinned out and the gross examination shows extensive destruction of kidney tissue. Microscopically the kidneys show extensive fibrosis with dilatation of the renal tubules and destruction of the kidney parenchyma. Practically all of the glomeruli are fibrosed. The tubules show large numbers of casts.

The small intestines show numerous patches of fibrin over the peritoneal surface especially of the jejunum and ileum. In the ileum, about 60 cm. from the ileo cecal junction, there is an area about one meter long where the intestinal mucosa has a dark reddish-purple color and shows several rough grayish ulcers, one of which has perforated. There are three similar ulcers in the ileum. The mesenteric lymph nodes are enlarged.

Microscopic sections of the intestinal ulcers show a marked necrosis which has destroyed the mucous membrane and extends down into the submucosa, which is infiltrated with small round cells. Below the area of necrosis there are numerous areas of hemorrhage and all of the blood vessels in the vicinity are dilated and engorged with red blood cells.

Both the gross and microscopic appearances of the intestines are characteristic of the pathological picture described as uremic ulceration of the intestine.

Uremis ulcerations of the intestines were noted in 1846 by Malmsten,[5] who described chronic ulcerative and pseudomembranous inflammation of the bowel in chronic nephritis. Treitz[6] in 1860 discussed the condition and reported one case. He believed the intestinal ulcerations to be caused by urea. Wilks and Moxon[7] mention similar ulcerations in the duodenum, stating that "these we have seen as single reniform or circular erosions, generally near the pylorus; sometimes they are quite shallow, and little blood extravasated in the mucous membrane around, would give rise to the suspicion that hemorrhage into the tissue weakening it and leading to its solution may be the cause of such ulcers."

Dickinson[8] in 1876 described two cases and in a later article published in 1894[9] made a very exhaustive study of the condition. He collected twenty-two cases, in twenty of which the kidneys showed extensive fibrosis. Seven of the cases showed perforation with peritonitis. He thought the ulcerations dependent upon an effusion of blood in the submucous coat. Perry and Shaw[10] collected sixteen cases of ulceration of the duodenum in nephritis, Barie and Delauney[11] reported one case of duodenal ulcer and collected eighteen others. Barie and Delaunay discuss and emphasize the role of the intestine in the elimination of toxins and blame the ulcerations upon the uremic poison. Mackey[12] reports two cases of uremic ulceration, one of which showed three perforations in the ileum.

These observations from the literature together with our own case, show that uremic ulceration of the intestine, while an unusual condition, is a well defined complication of chronic nephritis. A certain number of these cases succumb directly as the result of perforation of these ulcers with a complicating peritonitis. The pathological picture of these ulcerations suggests strongly that hemorrhage into the submucous tissue plays an important role in producing the necrosis and subsequent ulcerations. Toxins may also assist by either inciting the hemorrhage or by direct action and the intestinal bacteria doubtless assist in producing the membranous inflammation.

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Clinical Eponymic Signs.

For a very long time it has been the custom to designate certain signs, symptoms or groups of symptoms by the name

of the man who first described or reported them. In this way the list has continually grown until, at this time, but few of us are able to keep but a small number of them in mind. We have compiled a list of such signs, using various dictionaries and other sources of information, and will publish the list in monthly instalments.

ABADIE'S SIGN—Spasm of the levator palpebræ superioris in exophthalmic goiter.

AHLFELD'S SIGN—Irregular tetanic contractions affecting localized areas of the uterus, observed after the third month of pregnancy.

ALLIS' SIGN—Relaxation of the fascia lata between the iliac crest and the trochanter major is indicative of fracture of the neck and femur.

ANDRAL'S SIGN—Decubitus on the sound side; a position assumed in the early stages of pleurisy.

ANGELESCU'S SIGN—A sign of tuberculosis of the vertebræ, consisting in inability to bend the spine while lying on the back so as to rest on the head and heels alone.

ARGYLL-ROBERTSON PUPIL SIGN — One which is miotic and which responds to accommodation effort, but not to light.

ARNOUX'S SIGN—A sign of twin pregnancy, consisting of a peculiar rhythm in the fetal heart-beat produced by the action of the two hearts and resembling the sound of the hoofs of a pair of trotting horses.

AUBERT'S PHENOMENON—An optical illusion by which, when the head is inclined to one side, a vertical line is made to appear oblique toward the opposite side.

AUENBRUGGER'S SIGN — Bulging of the epigastric region in cases of extensive pericardial effusion.

AUFBRECHT'S SIGN — Short and feeble breathing heard just above the jugular fossa on placing the stethoscope over the trachea; it is noted in tracheal stenosis.

AVELLIS' SYMPTOM—Complex. Paralysis of one-half of the soft palate, associated with recurrent paralysis on the same side.

BABINSKI'S PHENOMENON OR REFLEX—"Phenomene des orteils." Extension instead of flexion of the toes on exciting the sole of the foot. It is connected with a lesion of the pyramidal tract and found in organic, but not in hysteric, hemiplegia.

BABINSKI'S SIGN—Diminution or absence of the Achilles tendon reflex in true sciatica as distinguished from hysteric sciatica.

BACCELLI'S SIGN—Aphonic pectoriloquy. The whispered voice is transmitted through a serous but not through a purulent pleuritic exudate.

BAILLARGER'S SIGN—Pupillary inequality in paralytic dementia.

BALLANCE'S SIGN—Resonance of right flank when patient lies on his left side; seen in splenic rupture.

BALLET'S SIGN — Ophthalmoplegia externa, characterized by the loss of all voluntary movements and integrity of the movements of the eyeball, with preservation of the automatic movements and integrity of the movements of the pupil. It is seen in hysteria and exophthalmic goiter.

BAMBERGER'S SIGN—1, Allochiria; perception of a stimulus applied to the skin of one extremity at the corresponding place on the other extremity. 2. Presence of signs of consolidation at the angle of the scapula, which disappear when the patient leans forward; sign of pericardial effusion.

BARD'S SIGN—To differentiate between organic and congenital nystagmus. In the former the oscillations of the eyeball increase when the patient follows the physician's finger moved before his eye alternately from right to left, and from left to right. In the latter the oscillations disappear under these conditions.

BARUCH'S SIGN—The resistance of the rectal temperature to a bath of 75 degrees for fifteen minutes, with friction; it is pathognomonic of typhoid fever.

BASTEDO'S SIGN—The production of pain and tenderness in the right iliac fossa on inflation of the colon with air by means of a rectal tube; seen in chronic appendicitis.

BATTLE'S SIGN—Discoloration in the line of the posterior auricular artery, the ecchymosis first appearing near the tip

of the mastoid process; seen in fracture of the base of the skull.

BEAUME'S SIGN — Retrosternal pain in angina pectoris.

BECCARIA'S SIGN — Painful pulsating sensations in the occipital region during pregnancy.

BECHTEREW'S SIGN—Anesthesia of the popliteal space in tabes dorsalis.

BECKER'S SIGN—Spontaneous pulsation of the retinal arteries in exophthalmic goiter.

BEEVOR'S SIGN—A sign of functional paralysis consisting in inability of the patient to inhibit the antagonistic muscles.

BEHIER-HARDY'S SYMPTOM—Aphonia, an early symptom in pulmonary gangrene.

BELL'S PHENOMENON—Upward and outward rolling of the eyeball upon an attempt to close the eye of the affected side in peripheral facial paralysis.

BELL-BERNHARDT'S PHENOMENON — See Bell's phenomenon.

BENEDIKT'S SYMPTOM—Complex. Tremor of one side of the body, in part or wholly, and oculomotor paralysis of the other side.

BERNHARDT'S SIGN. BERNHARDT-ROTH'S SYMPTOM—Complex. BERNHARDT'S PARESTHESIA — Perverted and painful sensations on the outer and anterior surfaces of the thigh; experienced in displacement of the external cutaneous nerve.

BERGER'S SIGN—An elliptic or irregular shape of the pupil sometimes seen in the early stage of tabes and paralytic dementia, and in paralysis of the third cranial nerve.

BEZOLD'S SYMPTOM—The appearance of an inflammatory swelling a short distance below the apex of the mastoid process is evidence of mastoid suppuration.

BIERMER'S SIGN — 1. The absence of laryngeal movements in dyspnea due to aneurism of the aorta. 2. Change of percussion-sound on change of the patient's position; seen in pneumothorax and in pulmonary tuberculosis.

BIERNACKI'S SYMPTOM—Analgesia of the ulnar nerve at the elbow; it is observed in tabes dorsalis and paretic dementia.

BIRD'S SIGN—A well-defined zone of dullness with absence of the respiratory sound in hydatid cyst of the lung.

BLUMBERG'S SIGN—Short acute pain felt by the patient when the examiner's hand is pressed over McBurney's point and lifted up suddenly; it occurs in all forms of peritoneal inflammation.

BOAS' SIGN—The presence of lactic acid in the gastric contents in cases of cancer of the stomach.

BOLOGNINI'S SIGN—On pressing with the tips of the fingers of both hands alternately upon the right and left of the abdomen of a patient who is lying on his back and whose abdominal muscles are relaxed by flexion of the thighs, a sensation of friction within the abdomen is perceived; it is noted in the early stages of measles.

BORDIER-FRENKEL'S SIGN—An outward and upward rolling of the eye in peripheral facial paralysis.

BOSIERI'S SIGN—When the finger nail is drawn along the skin in early stages of scarlet fever, a white line is left which quickly turns red.

BOSTON'S SIGN—In exophthalmic goiter, when the eyeball is turned downward there is arrest of descent of the lid, spasm, and continued descent.

BOUTILLAU'S SIGN—A peculiar tinkling at the right side of the apexbeat in hypertrophy of the heart.

BOUVERT'S SIGN IN INTESTINAL OBSTRUCTION—Applicable only to the large gut. Great distension of the cecum, and a large elevation in the right iliac fossa.

BOZZOLO'S SIGN—Visible pulsation of the arteries of the nares, said to occur in some cases of aneurysm of the thoracic aorta.

BRAUCH-ROMBERG'S SIGN — See Romberg's sign.

BROWN-FERNWALD'S SIGN — A symmetric enlargement of the uterus, one side being greater than the other, with a longitudinal line or furrow separating the two.

BRAXTON-HICKS' SIGN—See Hicks.

(To Be Continued)

THE JOURNAL
of The
Kansas Medical Society

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Ethics in Medicine.

Good and learned men have for centuries preached ethics and morality and religion all over the world, and yet we are not shocked or surprised that there should be occasional criminals in every community, in every station in life, in every class and occupation. In none of these will there be found all honorable men. In the medical profession, there are a few afflicted with moral squint, a few whose ideas of rectitude are perverted and perhaps a few in whom a reversion to the primitive type is manifest, but the great mass of the profession is made up of honorable men in whom gentlemanly instincts predominate. With these the path of least resistance lies with morality and rectitude, with due regard for their obligations to afflicted humanity, with a full recognition of the rights and privileges of their confreres. No rules of conduct need be prescribed for such as these, their instincts guide them. The code of Medical Ethics, or, as its revision is now known, "The Principles of Medical Ethics," is but an elucidation of the general principles of ethics by which all honorable men are instinctively governed.

There is nothing in the Principles of Medical Ethics that imposes a burden upon any conscientious practitioner, nor is there any loss to one who adheres strictly to these ethical rules.

The spirit of commercialism with which the practice of medicine has of late been contaminated does not by any means imply or require a surrender of any of the virtues one may have inherited or acquired.

While the spirit of commercialism grows more arrogant in the practice of medicine, the ethical principles which have governed physicians in their relation to each other and their patrons are being quite generally adopted by the larger and better commercial concerns. Business which is secured by questionable or dishonest means is likely to be undesirable business. A physician who resorts to unfair or unethical practices in securing business loses the respect of the people. The history of the practice of medicine in every town will show that the unethical man is eventually the loser.

In spite of the fact that every member of the society has subscribed to the principles of ethics and is under obligation to abide by them, it is not always wise to suspend or expel a member for unethical conduct.

Dr. McCormick used to say that such a man could be controlled in the society much better than out of it. United action by the society sometimes makes a man stubborn and willful, while individual persuasion and personal influence may do wonders in the way of reformation. One who feels that all the other physicians in his town are "down on him" is not likely to respect their rights and privileges. Convince him to the contrary and he may be an excellent good fellow. There are many men in the practice of medicine who are suspicious of their fellows and are hard to convince that one means anything but harm to them. The greatest reforming influence is kindness. If a man does you a serious wrong, wait until you have an opportunity to do him an equal kindness and be sure that he has reliable knowledge of it. If he is proud, it will be the greatest punishment you can inflict and he will be

careful of his conduct toward you and your business. If he has no pride and no conscience, he won't last long any way—just let him alone.

The Miller Bill for the Control of Venereal Diseases.

A bill has recently been introduced in the House of Representatives by Congressman John F. Miller of Washington which provides in a measure for the control of venereal diseases.

The title of the bill is as follows:

To conserve and increase the industrial man power of the United States; to increase the efficiency of the military and naval forces thereof; enlarging the powers of the Public Health Service by creating and establishing a Division of Venereal Diseases therein; providing for the punishment of immoral persons afflicted with venereal diseases who go or attempt to go from one political division to another, and persons who assist or connive at the same; establishing internment hospitals; authorizing the Secretary of the Treasury to establish all needful rules and regulations relating to the subject matter of this Act; and authorizing an appropriation therefor.

It provides for the establishment of a Division of the Public Health Service to be known as the Division of Venereal Diseases; and further provides for the appointment of an Assistant Surgeon General of the Public Health Service to have charge of this division. It confers upon the Public Health Service power and authority to study, investigate and conduct research work into the cause, prevention, and treatment of venereal diseases; to construct, acquire, purchase, lease, or otherwise obtain internment hospitals, and to equip, manage, conduct, and operate the same; to administer and apply medical treatment to persons afflicted with venereal diseases while in said internment hospitals, and to issue orders of dicharge therefrom upon cure; to cause the arrest and prosecution of immoral persons afflicted with venereal diseases who go or attempt to go from one political division to another, and to cause the arrest and prosecution of persons who aid, assist, or connive at same; to detain for purposes of medical observation or examination and treatment any immoral person going or attempting to go from one political division into another, and to commit any such person afflicted with venereal disease to an internment hospital; to administer medical treatment to such person and have legal custody thereof.

It defines the term "political division" as any state, district, or insular possession of the United States; and defines the term "immoral person" as any bawd, prostitute, or female who practices sexual intercourse out of wedlock for or without hire or thing of value; or any man who consorts with, associates, or companions with any immoral woman, or who loiters about or frequents any bawdy house or brothel; or any bawd or other lewd or licentious person.

It further provides for the appropriation of three and one-half million dollars for the purposes of carrying out the provisions of this bill.

There is no question that this bill deserve sall the support the medical profession may be able to give. It is in perfect harmony with present public sentiment and should meet no serious opposition in its passage. Such a measure, in connection with proper legislation in the various states, should be very effective in the ultimate eradication of venereal diseases in this country.

Who for Governor?

Some of the doctors in Kansas seem to think that there is still a possibility of electing a man for governor who is not too closely identified with the interests of christian science, sectarian medicine, and all the other substitutes for real physicians, to give due consideration to the interests of the people and lend his support and influence in behalf of higher standards for practitioners of the healing art.

Judging from the material from which the candidates are to be selected one may,

at least, be more than usually hopeful.

Some years ago we felt like congratulating ourselves on the part we played in the election of Mr. Hodges. We were led to believe that he was heartily in sympathy with the cause of higher standards of medicine. Whether his friends made promises for him or, as he said, he did not give sufficient consideration to the contents of the bills that were passed, it is a fact that he permitted some pernicious legislation to stand. It seemed to most of us that he had utterly failed to keep the trust.

At the next election the three candidates each gave us letters in which their support of the principles we advocated was at least implied. We then voted according to our individual political affiliations. Mr. Capper assured us that he "was in hearty sympathy with every movement which has for its object the elevation of your standards." Although efforts were made to secure some important legislation along this line, Mr. Capper has so far had no opportunity to demonstrate his attitude on the questions with which we are intimately concerned. We are informed, however, that he has repeatedly expressed his willingness to sign such bills as should be passed by the legislature.

At that election time Mr. Allen identified himself, more positively and emphatically than the others, with the movement for better medical legislation, and had included in his platform a plank determining his attitude on that subject. Mr. Allen is again a candidate for the nomination and we are justified in believing that his views have not changed in regard to medical standards.

We have no definite declarations from either of the other candidates for the Republican nomination, but there are records of the senate procedures from which one may draw fair conclusions.

During his first term in the senate Mr. Troutman seemed to be very closely identified with the osteopathic and chiropractic interests, particularly the latter; and there is nothing in his record as a senator, during the session in which these interests were much concerned, that would justify us in believing that he, as governor, would be favorable to any legislation tending to raise or unify the standards of qualification for the practice of the healing art.

However, we are credibly informed that during the next session of the legislature Mr. Troutman showed some evidences of a change of heart, and his more optimistic friends are quite willing to vouch for his co-operation in any movement for higher standards of medicine.

We have it from the best authority that when Mr. Brewster was in the Senate he could be relied upon to support any measure which had for its object the raising of the standards of medical practice.

We are also assured upon equally good authority that Mr. Morgan is in sympathy with every movement for the betterment of the practice of medicine, and can be depended upon to support any measure that has this for its object.

Kansas is normally Republican and under normal conditions should give the Republican candidate a safe majority—a larger majority than the very best efforts of the combined medical men of the state would be able to overcome. But we are not all Republicans nor all Democrats, and in the event of an unusually close contest it will require a very definite and important issue to influence many of us to ignore party affiliations. It is well at this time for us to use whatever political influence we may have toward the nomination of candidates who can be depended upon to maintain the present standards of the practice at least. It is not likely that any measure tending to increase the present standards would meet with much success during the war. The scarcity of real doctors is already being badly felt by the people and such substitutes as can be supplied will have to be depended upon until the return of those in the field. By that time it is more than likely that the people will have learned the difference between thoroughly educated practitioners of medicine and the various sects that are trying

to supplant them. The condition in many parts of the state is becoming serious, in two whole counties there is now not a doctor, and it is very difficult to find men to fill really desirable locations. It will not be surprising, therefore, if some effort is made to extend the privileges and scope of practice of the various kinds of drugless healers. Any legislation of this kind-should certainly be prevented and it behooves us to be sure that the man elected governor of the state will realize the necessity for maintaining the present standards of qualification.

In so far as the medical profession of Kansas is concerned, there will be but one candidate for Lieutenant Governor, and that will be Dr. Chas. S. Huffman, now Adjutant General. Dr. Huffman has been so intimately identified with the profession of the State and has so faithfully looked after our interests in the Senate that he is not only entitled to all the support we can give him in his candidacy for this office, but for any other office he may want.

We all know him, we all like him, and we will all vote for him.

No Slackers Allowed.

If you have the slightest idea that you will not apply for a commission when asked to do so, just read what Dr. Edward Martin said at the meeting of the State Committees with the General Medical Board:

"We wish to formulate a plan by which we may deliver to the Surgeon General of the Army 5,000 medical men before the first of July, and probably many more within the next year. The tentative scheme is this: That each State committee, with the help of the county committees where this seems desirable, take their tabulated lists of the profession in their State and select from that list twice as many men as will be wanted in this first call and to notify each one of those men. The problem is different in each State, and each State must settle it for itself. Suppose the man refuses. What is your next step? We will then ask you to send his name to the committee's office in Washington. He will then receive a direct appeal to enlist, because you have said he should. Suppose he refuses. We have nothing more to say, but we believe that any man who, after that, refuses to go into the service will find hell a more comfortable place. So you have them. We are after them. Our honor is involved. Our duty is to get them, and you will do it."

Examiners for Medical Officers.

So many have written to know about the examiners that we publish herewith the list of examiners for Kansas. Fill out your application and send it to the nearest of these and wait until you are notified to appear for examination:

Newton—Lieut. L. T. Smith, M.R.C.

Fort Riley—The surgeon.

Fort Leavenworth—Lieut. Joseph Howard Langworthy, M.R.C., post hospital.

Dr. F. J. Hackett, in charge of the contagious wards of the Camp Upton Base Hospital, in connection with a paper on "Measles" from the standpoint of military medicine, said regarding the open air treatment that his procedure has been in the opposite direction, all the patients being kept in warmed, well-ventilated wards. He felt that the low death rate had been because of this. It had been the universal experience of the camp hospitals that measles cases in adults always did better in well warmed wards and the cases of post-measles pneumonia were low among those so treated.

A letter just received from Dr. C. F. Young, Secretary of the Bourbon County Society, states that he has received two applications for membership and with the admission of these two members Bourbon County will be one hundred per cent pure. This means that the fellows in Bourbon County are all first class, progressive men, and that they have a Secretary that is a live one.

Excerpts

By The Prodigal.

"Don't spit on the floor. But if you spit on the floor at home, spit on the floor here. We want you to feel at home."

The above request and welcome is on a placard posted on a cigar stand in a little hotel in Lancaster, Antelope Valley, California. The quaintness and oddity of expression attracts attention; and the spirit of good will it breathes, and the sense of common decency it inspires, and the faint odor of ridicule exhaled, and the precaution it suggests, makes it an aphorism worth while.

The wording and the effect it has on the public makes on think that scientific medical facts are better understood and obeyed by the laity if worded in plain every-day language. It also appeals to decency. The fear of disease is not as great as the fear of ridicule, often, and a health rule is obeyed by some persons through pride of being thought cleanly rather than the fear of disease.

The California Industrial Commission has handed down a decision that tuberculosis is not a contagious disease.

Although a little camouflaged, there is too much truth in the following: "Our medical knowledge is largely what remains when what we have learned in college has been forgotten."

EXPERIENCE.

Experience is the best teacher. It is an exacting teacher and permits no monkeying. Experience has taught me that if the parents eat sour grapes it is likely to set the children's teeth on edge. Later this was called inherited disease; and later on it was smoothed out, ethicalized, predispositioned, and the psychological sting was taken out of it. I do not know what it is called now. I do know that my father had what was called inherited dyspepsia at thirty years of age and was afflicted the remaining years of his life—some forty-eight years. I followed suit at forty-five years old, and have had a monkey and parrot time of it for the past twenty-eight years. In my case it is called gastroptosis, dilation of the stomach, atonic dyspepsia and other names too numerous to mention. My son took the initiative at the age of forty-one and has been attending strictly to the whims of his digestive apparatus for the past four years, with the prospect of a life performance.

Hence I have concluded: That no two persons having the same identical chronic digestive disease, so far as human intelligence can determine, respond to the same treatment or diet. What relieves or agrees with one fails to benefit or to agree with the other one. The observant physician knows this and he is bumped up against empiricism. Either that or his patient begins to vibrate.

Again, the same diet or medicine which agrees with the patient today may disagree with him later on. The palate is not an unerring guide in the selection of the kind of food, for it is more or less perverted, yet it must not be totally ignored. In my own case I craved vinegar. It was thought best to take hydrochloric and other acids, but none of them were tolerated by the stomach, and for three years I took a tablespoonful of vinegar, raw, before eating—almost every meal. The vinegar satisfied the craving and digestion was fairly comfortable. At the expiration of that time the craving for vinegar ceased entirely and I quit taking it.

I found that the fewer foods taken at one time, the better. Not to exceed two, better one at a time, varying the kind at different meals. Milk was poisonous to me, due to constipation. Ice cream was the evening meal for many months. Often one kind of food will agree, but mixed with other foods at the meal will disagree with such patients.

From three to ten drops of the tincture of belladonna or two to five drops of the fluid extract, taken an hour after meals, will relieve the pain in the stomach if caused by spasm of the pylorus. From one to two tablespoonfuls of petrolatum,

taken once or twice a day, will aid the digestive apparatus mechanically. If too much of the petrolatum is taken it will pass from the patient involuntarily and prove annoying. In case of sour eructations from the stomach, a half to a teaspoonful of bicarbonate of sodium, taken in a little water, will correct the acidity and is laxative.

To sum up my experience, will say:

1. A single simple diet.
2. Strict hygiene of the body.
3. Exercise in the open air and sunlight every day.
4. Abdominal calesthenics.
5. Put the city chap on a ranch and the country chap in a sanitarium.
6. System and regularity in work, sleep, eating and play or amusement.
7. Get the patient to say at all times that he is happy and it will become a habit. Later he will believe it and is safe.
8. Bicarbonate of sodium, belladonna and petrolatum as therapeutic agents.

Since so much personality has been injected into these remarks, I desire to say that for the past eight years my health has been about the average of men of my age, and the change was caused by my going onto a ranch and working, as my strength would allow, in the sunshine.

Proceedings of the Fifty-Second Annual Meeting of the Kansas Medical Society, Held at Kansas City, Kansas, May 1, 2 and 3, 1918.

MEETING OF THE COUNCIL.

The Council met at the Scottish Rite Temple, Wednesday, May 1, at 10 a. m., with the following members present:

President Dr. Chas. S. Huffman; Acting Secretary Dr. L. F. Barney; Treasurer Dr. L. H. Munn, and the following Councillors: Dr. C. C. Goddard, Dr. J. A. Dillon, Dr. D. R. Stoner, Dr. O. P. Davis, Dr. H. N. Moses. Dr. W. E. McVey, editor of the Journal, was also present.

Dr. Goodard, Councilor of the Second District, submitted the following report:

REPORT OF COUNCILOR OF SECOND DISTRICT.

During the year past I delivered six lectures; four outside and two within the Second District—one at Norton, Kingman, Concordia and Salina, respectively; one at Garnett and one at Lawrence, within the district. The units of the Second District are all affiliated and doing more or less good work. Each county has furnished a good quota to the Medical Corps of the Army and more are ready to go if needed.

Respectfully,

C. C. GODDARD,
Councilor, Second District.

Dr. H. N. Moses, Councilor of the Eighth District, submitted the following report:

Medical Societies:

Saline County Medical Society—Pres., John K. Harvey; Secretary, W. E. Mowery. Membership, 20 from Saline County, 10 from Ottawa County. Meetings, five at Salina. Seven of the former members in the service.

Lincoln County Medical Society—President, O. R. Wolfe; Secretary, Malcolm Nelwon. Membership, 10. Meetings, five at Lincoln. Three of the members in the service.

Central Kansas Society—President, Alfred O'Donnell; Secretary, W. M. Reitzel. Membership, 15 from Ellsworth, Russell and Ellis Counties. Meetings, three at Ellsworth. Four members in the service.

Total for district: Number of doctors, 85; members of Local Society, 48; number of doctors in the service, 14.

Notation by counties in the Eighth District:

County	Doctors	Members of Society	In Service
Saline	40	20	4
Ottawa	13	6	3
Lincoln	9	7	3
Ellsworth	8	5	2
Russell	10	5	1
Ellis	11	5	1

Respectfully submitted,

H. N. MOSES,
Councilor, Eighth District.

Dr. D. R. Stoner, Councilor for the Tenth District, submitted the following report:

To the Officers and Members of the Kansas Medical Society:

As Councilor for the Tenth District, I beg to submit the following report: The Tenth District includes the counties of Gove, Trego, Graham, Sheridan, Thomas, Logan, Wallace and Sherman. The counties of Logan, Thomas, Gove, Sheridan, Graham, and Trego, have been visited during the year. We have only the one Medical Society in the district—the Tri-County Medical Society. The past year, meetings have been held at Hoxie, Goodland, Hill City, and Oakley; also one joint meeting with the Central Kansas Society.

Our membership for the year past has been the largest in the history of the Society. It being impossible to organize the individual counties, the Tri-County Medical Society has a large percentage of the eligible physicians, as will be seen by the following summary:

County	M.D.	Eligible	Members	Removals	Deaths	Enlisted	A.M.A.
Gove	6	5	5	0	1	1	5
Trego	6	6	4	1	1	0	4
Graham ..	7	6	5	1	1	2	3
Sheridan .	4	4	2	0	0	0	2
Thomas ..	4	3	2	1	1	2	2
Sherman .	4	4	3	0	0	1	3
Wallace ..	3	3	3	1	0	0	3
Logan ...	4	3	2	1	0	1	2

Members in service: Lieutenants Guy Winslow, Grainfield; C. M. Miller, Oakley; E. J. Beckner, Goodland.

Deaths during the year: Dr. J. M. Eisenbise, Quinter; non-members, Drs. William Beaver, Colby; A. J. VanDuyn, Mill City; A. B. Jones, Wakeeney.

In a general way, I think the Tenth District is in a very prosperous condition at this particular time.

Respectfully submitted,

D. R. STONER, M.D.,
Councilor, Tenth District.

Dr. J. A. Dillon, Councilor of the Eleventh District, reported a plan of their society of having the Dental Society meet with the Medical Society and having one paper from each society at the meeting.

Dr. H. N. Moses, Councilor for the Eighth District, reported that Saline County had one meeting, annually, in which the Dental Society participated.

Dr. O. P. Davis moved that the Council recommend to the House of Delegates that the Secretary, Dr. J. F. Hassig, be granted a leave of absence during the war and that Dr. L. F. Barney be made Acting Secretary during the absence of Dr. Hassig.

Meeting adjourned.

May 1, 1918.

The regular session of the Kansas Medical Society convened at the appointed hour to listen to the address of the President and the reading of the various scientific papers on the program, and the discussions of same.

May 2, 1918.

A special "War Day" program was prepared for this day, and doctors from outside the state were invited to address the meeting. Dr. H. M. Richter and Dr. James N. Neff, both of Chicago, gave very interesting papers on their experiences in German and English Base Hospitals, respectively. Dr. Robinson and Dr. Sachs, both of St. Louis, presented excellent papers relating to war subjects. Dr. Jabez N. Jackson of Kansas City, Mo., and Colonel W. N. Bispham of Ft. Riley also gave fine talks.

MEETING OF THE HOUSE OF DELEGATES.

The meeting was called to order by the President, Dr. Chas. S. Huffman, at 7:30 p.m., Wednesday, May 1.

On motion, seconded and carried, the reading of the minutes of the last meeting was dispensed with. Next in order of business was the report of the different officers.

SECRETARY'S REPORT.

To the House of Delegates:

I desire to submit the following report for the year ending May 1, 1918:

Balance on hand May 2, 1918		$?,???.??
Divided as follows:		
Medical Defense	$2,201.28	
General Fund	5,406.11	
Total		$ 7,607.39
Amount received from all sources for year ending May 1, 1918:		
Dues from Members	$2,751.00	
Received from Editor of Journal	681.33	
Total amount received		$ 3,432.33
Total		$11,039.72
Amount paid out for the year ending May 1, 1918:		

Medical Defense	$1,019.58	
General Fund	2,688.42	
Total		$ 3,708.00
Balance on hand May 1, 1918		$ 7,331.72

I do not feel competent at this time to make a report of the condition of our Society, for, as you know, Dr. Hassig was called, very suddenly, to the service, March 1; and while he had everything in tip top shape, I am forced to admit that I have not, as yet, learned the workings of the Society in detail. My excuse for this is the same that is usually given—haven't had the time. This excuse at this time I feel is at least partially legitimate when we consider the strain that all practitioners are put upon on account of so many being away at the front. But until Dr. Hassig returns, if you will bear with us, we shall endeavor to keep things going as best we can.

Our program for this meeting would not have been even as good as it is had it not been for the excellent preparation already made by Dr. Hassig before he was called to the service, and the assistance we have had from our officers and the Council of National Defense. Here I would like to mention and thank our worthy President, Dr. Chas. S. Huffman, Dr. W. E. McVey, editor of the Journal, Dr. Gray, Dr. Sudler and others who have so kindly come forward at this critical time. Many who have gone on the program have done so not of their own volition but to aid, because they knew of the dire need. These I again wish to thank.

Our Society has about the same membership as that of last year, namely 1,500. Of these, 265 have enlisted in the Medical Reserve Corps and are not with us now, and many of these were our most active members. Now as you know, there is a drive on for 5,000 more doctors, and the present plan is for at least 2,500 more each year. The longer the war continues, the greater will be the necessity of a medical organization, and right here I wish to emphasize to those remaining at home their duty in keeping up our organizations. In this drive our parent organization, the American Medical Association, has volunteered to furnish the doctors. They depend upon the State Societies, and the State Societies, in turn, depend upon the County and District Societies, hence the necessity of keeping them all alive and active. I call attention to this at this time particularly because already we have had difficulty in getting response from the local societies, many apparently having dropped out of existence.

Many societies that are not a part of the national organizations have already disbanded, and if the war continues the majority will do likewise, and this makes the necessity for the continuation of the American Medical Association and its subordinate organizations all the greater, for it is the one upon which we shall have to depend entirely in the future.

Respectfully,

L. F. BARNEY,
Acting Secretary.

On motion carried the report was accepted and placed on file.

TREASURER'S REPORT.

To the House of Delegates:

I desire to submit the following report for the year ending May 2, 1918:

Balance on hand May 1, 1917		$ 7,607.39
Cash received from your Secretary		$ 3,432.33
Total amount of cash		$11,039.72
Amount paid out to May 1, 1918:		
Defense Fund	$1,019.58	
General Fund	2,688.42	
Total expenditures		$3,708.00
Balance on hand		$ 7,331.72
Of this amount we invested in Liberty Loan:		
Second issue Liberty Loan	$3,000.00	
Third issue Liberty Loan	1,500.00	
Total amount in Liberty Loan		$4,500.00
Balance in bank subject to check		$ 2,831.72

The report was accepted and placed on file.

Dr. Munn asked that an auditing committee be appointed and the president appointed Dr. M. F. Jarrett, Dr. L. O. Nordstrom and Dr. D. R. Stoner.

EDITOR'S REPORT.

Your editor respectfully submits for your consideration the following report of

the financial condition of the Journal for the fiscal year ending May 1:

Subscriptions (1,450) from members	$2,900.00
Subscriptions from non-members	7.50
Receipts from advertising	3,143.35
	$6,050.85
Cost of publication	$ 3,028.77
Earnings	$ 3,022.08

And the following statement of the account of the Editor with the Society:

Received from Treasurer	$1,000.00	
Received from Advertising	3,143.35	
Received from Subscriptions	7.50	
		$4,150.85
Expended for printing Journal	$1,654.80	
Expended for other printing	45.75	
Expended for mailing	39.50	
Expended for postage	109.30	
Expended for miscellaneous	179.42	
Expended for salary	1,000.00	
		$3,028.77
Balance		$1,122.08

The report was accepted and placed on mile.

Dr. Sawtell made a report of the Committee on Public Policy and Legislation. Dr. S. J. Crumbine reported for the Committee on Public Health and Education.

Dr. O. P. Davis reported for the Medical Defense Board as follows:

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE.

The Medical Defense Board begs to submit the following report, covering work to date:

There have been only five new cases brought within the past year. A good many cases are still pending which have been dragging along from previous years. It is a noteworthy fact that the weaker a case is, the longer the plaintiff tries to nurse it along without letting it come to trial, in the hope that the defendant will grow tired of the annoyance and worry and offer to settle. It is still the inflexible policy of this Board to refuse to settle, and when a member does settle or compromise in the cases it is entirely contrary to our advice, without our consent and against the best interests of the defense movement. We fight these cases not merely for the benefit of the accused, but also for the benefit of the profession at large. It is only by fighting these cases to the last ditch that the growing habit of maliciously suing doctors can be checked.

Our good record in the defenes of suits brought against our members from the institution of this Board is well set forth in the report of our attorney, which is herewith submitted as a part of this report. But it must not be thought that we can now safely relax our efforts or discontinue any of our defensive provisions because of the diminishing number of suits instituted each year. Any weakness or lack of diligence shown along this line will readily be taken advantage of by the birds of prey that are always to be found in every community.

Our attorney has briefly discussed in his report the new organization that has been formed to take care of judgments and supplemental legal assistance for the members. This has been a deficiency that has been felt by this board and a talking point used against us by the men who go up and down the state selling indemnity insurance to physicians. The argument is well taken, and although we hope our members will be always successfully defended, yet there is always the possibility of judgment to pay. It is always an advantage to have a local attorney to cooperate in the case, to aid in the selection of a jury and for the local influence thus secured. All this, obviously, cannot be done on the dollar a year the member is now paying for defense. It has to be done by some organization, which though independent of the Society organization is yet closely correlated with it. This, we think, has been accomplished as is set forth in Mr. McKeever's report. We are not boosting for a selfish or money-making organization, but for one that has grown out of a real need and that is being promoted and maintained without profit to anyone.

We wish to commend the skill and fidelity with which our attorney, Mr. McKeever, has handled the business of the Board, and the uniform success that has

followed his conduct of our cases. He has been always ready to go out and give his untiring personal attention to our business and has always been thoughtful in helping to conserve the limited financial resources available to our use.

The vouchers listed below cover the expenditures for medical defense during the past year:

1917	
No. 26—E. D. McKeever, salary May and June	$100.00
No. 27—O. P. Davis, postage	1.50
No. 28—E. D. McKeever, salary July and Aug.	100.00
No. 29—E. D. McKeever, expenses, Fredonia, and per diem	39.69
No. 30—E. D. McKeever, expenses and per diem Mitchell vs. Russell	58.89
No. 31—E. D. McKeever, salary Sept. and Oct.	100.00
No. 32—E. D. McKeever, expenses and per diem McRoberts vs. Clopper and Mitchell and Russell	22.73
1918	
No. 33—E. D. McKeever, salary Nov. and Dec.	100.00
No. 34—E. D. McKeever, expenses and services Needles vs. Lutz	62.33
No. 1—E. D. McKeever, expense to Ellsworth	24.44
No. 2—E. D. McKeever, salary Jan. and Feb.	100.00
No. 3—E. D. McKeever, salary March and Apr.	100.00
Total expenditures	$809.58

Respectfully submitted,

O. P. Davis, Chairman;

D. R. Stoner.

REPORT OF ATTORNEY FOR DEFENSE BOARD.

In this, my annual report, I am pleased to state that during the six years I have been attorney for your Defense Board, no judgment had been obtained against any member of the State Medical Society in any case reported to me, although there have been about thirty-five cases filed. The cases tried have been either beaten with a jury, demurred out of court at the close of plaintiff's evidence, or, in about four cases, a hung jury. In no case where the jury hung has there been a second trial to date. In about four cases so far as I know there have been settlements made in very small amounts. These were made without my knowledge and consent and over my objection, because in each of these cases there was no occasion for any settlement at all and the cases, in my opinion, could have easily been defeated and were in a fair way to be defeated when settlement was made. I do not think over $150 has been paid by any defendant in settlement of any case. The following is a list of the cases and their status and disposition:

The case of G. H. George vs. L. M. Shannon from Brown County was the first case handled by me in court in 1912. I received it after it had been tried in Brown County and judgment rendered against Dr. Shannon for $2,750 for an X-ray burn. I prosecuted the appeal to the Supreme Court and Dr. Shannon had to pay the judgment.

In the District Court of Shawnee County, Kansas, W. W. Bowman vs. A. and A. M. Dawson. $5,000. After several motions attacking the plaintiff's petition in this case had been sustained, the plaintiff gave up and dismissed it. Dr. A. M. Dawson is now in the military service. After the case was dismissed, he succeeded in running the attorney for the plaintiff out of the country and he has never returned.

In the District Court of Douglas County, Kansas. John N. Ashley vs. G. M. Liston, et al. $5,000. First case tried by a jury. Jury disagreed. Plaintiff afterwards dismissed the case.

In the District Court of Wyandotte County. Mary Brooks vs. Dr. Jefferson A. Davis. $10,000. After being continued for three or four years is dropped.

In the District Court of Neosho County. Mrs. G. R. Bridges vs. Dr. J. A. Edwards. $10,000. Tried by jury. Verdict for defendant.

In the District Court of Wyandotte County. Mary Gill vs. Dr. Z. Nason. $10,000. The case was ready for trial when Dr. Nason desired to take a vacation in the East and asked to settle for a nominal sum, which he did. This was done against my advice, but Dr. Nason expressed himself as highly pleased with the way the case was handled.

In the District Court of Linn County. W. E. Halliday vs. Drs. Wortman and Mills. $5,000. When case was ready for trial and counsel had the evidence in shape to defeat the case, Drs. Wortman and Mills settled the case for costs and attorney's fee. This was done in view of Dr. Mills

desiring to leave Linn County permanently.

In the District Court of Linn County. Grace Halliday vs. Drs. Wortman and Mills. $10,000. Disposed of the same as the above.

In the District Court of Saline County. Roberta Heck vs. W. E. Mowery and J. W. Neptune. $10,000. In this case we filed a counter-claim for Drs. Mowery and Neptune, which prevented the plaintiff from dismissing the case. Plaintiff is very anxious to dismiss the case and drop it, but Drs. Mowery and Neptune will not consent, as they want to recover their doctor's bills.

In the District Court of Crawford County. David Kelce vs. G. W. Williams and Wm. Williams. $2,500. Case dismissed and dropped.

In the District Court of Osborne County. O. F. Kruger vs. J. W. Lindley. $10,000. This case was tried by the jury and judgment for $90 doctor bill and costs.

In the District Court of Wyandotte County, Kansas. J. W. Roberts vs. D. E. Clopper. $10,000. This case has been pending several years. Plaintiff's attorney has offered to dismiss it if defendant will pay an attorney fee of $50, which defendant has declined to do.

In the District Court of Cloud County. A. F. Norton vs. A. G. Weaver. $5,000. Judgment for defendant on demurrer to plaintiff's evidence.

In the District Court of Douglas County. Martha Stillman vs. G. W. Jones. $5,000. Judgment for defendant on demurrer to plaintiff's evidence.

In the District Court of Cloud County. Mildred Woodruff vs. Drs. F. A. McDonald and G. S. Pigman. $5,000. After defeat of the Weaver case in the same county this case was dropped and dismissed.

In the District Court of Cloud County. A. E. Woodruff vs. Drs. McDonald and Pigman. $2,500. Disposed of same as above.

In the District Court of Allen County. J. E. Woolry vs. R. R. Nevitt. $10,000. Tried by jury. Verdict for defendant.

In the District Court of Allen County. T. M. Roberts vs. F. B. Leavel. $10,000. Tried by jury. Verdict for defendant.

In the District Court of Cowley County. Martin Lloyd vs. Drs. Young and Brock. $10,000. Jury case. Judgment for defendant on demurrer to plaintiff's evidence.

In the District Court of Pratt County. Helen Burnett vs. F. Peak. $5,000. After ready for trial defendant settled for a small sum without my knowledge.

In the District Court of Saline County. Henrietta Needler vs. E. J. Lutz. 25,000. Judgment for defendant on demurrer to plaintiff's evidence.

In the District Court of Shawnee County. Josephine A. Gustafson vs. L. M. Powell. $15,000. Thrown out of court on demurrer and ended.

In the District Court of Shawnee County. C. F. Gustafson vs. L. M. Powell. $5,000. Disposed of same as above.

In the District Court of Crawford County. Louis Paulich vs. Dr. F. E. Nipple. $5,000. Defendant's local attorney advised him to try this case without my assistance and ta the trial the jury hung, and Dr. Nipple has now called upon me to assist at the next trial.

In the District Court of Shawnee County. Lucy Trice vs. Dr. Seth Hammel. $9,785. This case had a count for malpractice which I had struck out on motion. The case was afterwards dropped.

In the District Court of Allen County. L. D. Johnson vs. John Allen. $7,132.70 The attorney for some indemnity company stated he would not need my assistance in this case and I do not know what happened to it.

In the District Court of Reno County. John Marriage vs. R. R. Gage and C. W. Hall. $5,600. This case is still pending.

In the District Court of Cheyenne County. Richard McCune vs. B. Jeffers. Counter-claim to $3,000 and suit on account of doctor bill. Counter-claim demurred out on authorities furnished by me, but I did not attend the trial, the judgment rendered for the doctor for his doctor bill.

In the District Court of Neosho County.

Anna M. Renner vs. John C. Henderson and J. J. McNamara. $10,000. Still pending. Dr. Henderson is in military service and Dr. McNamara seems to have left Neosho County.

In the District Court of Neosho County. John J. Renner vs. Henderson and McNamara. $10,000. Same as above.

In the District Court of Wyandotte County. Geo. Mitchell vs. G. J. Russell. $5,000. In this case the doctor made a mistake in diagnosis and the patient died. The case was tried by a jury and it stood seven for the doctor and five for the plaintiff. The case has been passed two or three times since the trial without being disposed of.

In the District Court of Jackson County. John Hamilton vs| Dr. W. F. Culbertson. It appears that Dr. Culbertson was a member of the Kansas State Medical Society. This case arose in Jackson County, Missouri, and the suit was filed in Missouri, and was not considered a proper case for the Defense Board to handle.

In the District Court of Wilson County. Bert Stewart vs| J. W. McGuire. $12,669.50. Still pending.

In the District Court of Mitchell County. Vietta Shaffer vs. Carl Brown. $5,000. This case is still pending. At the April term we announced ourselves ready for trial but plaintiff asked continuance until September.

In the District Court of Rooks County. Carruthers vs. Wolfe. Counter-claim and suit for services by Dr. Wolfe. Counter-claim demurred out of court and judgment for Dr. Wolfe for his doctor bill.

In the District Court of Riley County. Brandenberg vs. Colt. $10,000. This suit is pending, but in my opinion is barred by the statute of limitations and will be thrown out of court when our demurrer on the grounds is heard.

After about three or four years experience as attorney for your Board I discovered several unsatisfactory features about this defense system, namely: It furnishes no fees for employment of local attorney and does not pay the attorney for the Board adequate salary for the time and responsibility employed, and that, of course, that it does not pay any indemnity in case of judgment.

There is also another objection: That your attorney is compelled to defend cases of other indemnity companies insuring our members without compensation from these companies, and nearly all of these cases we defend, but the indemnity company took the credit for the successful defense. After a careful computation of the cost of defense and the history of our defense, I decided that the physicians and dentists in this state could carry their own expense of not to exceed $10.00 per year, payable in two installments of $5.00 each. I, therefore, recommended to your Board that an indemnity association be organized which would permit this kind of protection, if any dentist or physician in the state desired to avail himself of it. In pursuance of this recommendation, Dr. Huffman, who is a state senator, procured the passage of the law authorizing the organization of this company. Soon after the association organized with the officers of that association, the same as the officers of the Defense Board, adding, however, a few other directors. The officers and directors are the highest type of professional citizenship, and no person is eligible to membership in the association except such as are eligible to membership in the State Medical and Dental Societies.

This association takes care of every expense, including a judgment, if any is obtained, and has greatly exceeded our expectations in popularity and growth, so that at this time it is in a position to afford absolute protection to its members as fully and as effectively as any indemnity company doing business in Kansas. I give personal attention to each case as I do for the Medical Defense Board. At this time nobody connected with this organization is drawing a salary.

Associated in the organization, and holding the position of secretary and general manager, is Oscar Rice of Ft. Scott, Kansas, one of the most successful managers of any indemnity association in the

west. We were extremely fortunate to secure Mr. Rice and have him become associated with us in view of his demonstrated ability and wide and successful experience in the management of associations of this kind. Neither Mr. Rice or myself will draw any salary until the reserve on hands, which is rapidly accumulating, attains a substantial amount which will place the association beyond any possibility of failure to meet even unusual demands. At this time we have an ample surplus on hand which will more than protect the members against any loss that may be anticipated and do it effectively and promptly. And as stated, this surplus is increasing steadily.

It is a well known fact among lawyers that they do not waste their time on a doctor who has no standing professionally or financially, especially financially. So the fact that a physician is sued for malpractice does not necessarily imply any reflection upon his professional ability, but is merely a testimonial to the fact that he has been able to accumulate or retain some money, or at least give that appearance.

In the list of doctors who have been sued during my connection with the Defense Board I find many of the most reliable and ablest physicians; so that any one member of the profession is as liable to be sued as any other, as anyone can get an imaginary grievance and sue a doctor whether his grievance is real or not. I have found that 95 per cent of the cases are entirely without merit. The fee paid by a doctor for a local attorney in the average case would pay his assessments in our indemnity association for from ten to twenty years, and they can be paid in installments instead of a lump sum. Every doctor who is paying over $10.00 per year for indemnity insurance is paying that much more than is necessary and paying money which might be given to the Red Cross or devoted to the payment of grocery bills and other necessary expenses.

I have no hesitancy in unqualifiedly recommending our indemnity association to physicians in Kansas whether they have indemnity in other companies or whether they have none at all.

EDWIN D. MCKEEVER.

Dr. H. N. Moses moved that the House of Delegates act favorably on the recommendation of the Councilors that Dr. Hassig be granted leave of absence and that Dr. L. F. Barney be made acting secretary. Motion carried.

Dr. O. P. Davis moved that the place of any officer of the Medical Society, going into the service, be not declared vacant, but that the president appoint a man to fill the office temporarily. Motion carried.

MEETING OF THE HOUSE OF DELEGATES.

The House of Delegates convened Friday, May 3, 1918, at 9:00 a.m.

After the roll call, the following order of business was transacted:

REPORT OF THE AUDITING COMMITTEE.

We, the Auditing Committee, appointed by Dr. Chas. S. Huffman, president, May 1, 1918, hereby certify that we have examined the accounts of the secretary and treasurer, from May 1, 1917, to May 1, 1918, and find as follows:

Total amount on hand May 1, 1917		$ 7,607.39
Receipts during year from all sources		3,432.33
Total		$11,039.72
Disbursements:		
Medical Defense	$1,019.58	
General Fund	2,688.42	
Total		$3,708.00
Net balance on hand		$7,331.72

M. F. JARRETT
J. A. DILLON
L. O. NORDSTROM
Auditing Committee.

Report approved and placed on file.

Next in order was the election of officers for the ensuing year, and the following were elected:

President, Dr. W. S. Lindsay, Topeka.

Vice President, Dr. C. D. Blake, Ellis.

Vice President, Dr. E. E. Liggett, Oswego.

Vice President, Dr. J. L. Everhardy, Leavenworth.

Delegate to A.M.A., Dr. Chas. S. Huffman, Topeka.

Motion made and carried that the Delegates be allowed to select their own alternates to the meeting of the A.M.A.

COUNCILORS.

Dr. L. W. Shannon was chosen Councillor for the First District, Dr. C. C. Goddard of Leavenworth for the Second District, Dr. W. F. Sawhill of Concordia for the Seventh District, and Dr. H. N. Moses for the Eighth District.

The standing of the Council is as follows:

First District—Dr. L. W. Shannon, Hiawatha, term expires 1921.

Second District—Dr. C. C. Goddard, Leavenworth, term expires 1921.

Third District—Dr. P. S. Mitchell, Iola, term expires 1919.

Fourth District—Dr. O. P. Davis, Topeka, term expires 1920.

Fifth District — Dr. J. J. Brownlee, Hutchinson, term expires 1920.

Sixth District—Dr. E. S. Edgerton, Wichita, term expires 1919.

Seventh District — Dr. W. F. Sawhill, Concordia, term expires 1921.

Eighth District—Dr. H. N. Moses, Salina, term expires 1921.

Ninth District—Dr. C. S. Kenney, Norton, term expires 1919.

Tenth District—Dr. D. R. Stoner, Quinter, term expires 1919.

Eleventh District—Dr. J. A. Dillon, Larned, term expires 1919.

Twelfth District — Dr. E. M. Carter, Greensburg, term expires 1919.

It was moved and carried that the President appoint a committee to draw up resolutions to protest against osteopaths serving as examiners on Draft Boards and that these resolutions be presented at the next meeting of the A.M.A. The President appointed Drs. McNaughton, Stoner and Sawtell, who drew up resolutions and reported back as follows:

Whereas, the medical officers of the army and navy are selected only from those who are Doctors of Medicine,

Whereas, Osteopaths, Chiropractors and drugless practitioners of other classes are not recognized as competent for such military service, and

Whereas, in this state the appointment of an Osteopath on a Board of Examiners has been approved by the War Department after the protest of the regular profession,

Therefore, be it resolved, that we, the members of the Kansas Medical Society, now in annual session, express our disapproval of such recognition of drugless healers as competent to perform the important duties devolving upon such examining boards.

Be it further resolved, that a copy of these resolutions be forwarded to the proper authorities at Washington, and a copy of the same be also forwarded to the Medical Section of the Council of National Defense, and

Be it further resolved, that the delegates from this Society to the American Medical Association be instructed to present this matter to that body at its meeting in Chicago next June.

DR. D. R. STONER, Chairman;
DR. J. H. MCNAUGHTON
DR. J. E. SAWTELL.

Meeting adjourned.

MEETING OF THE COUNCIL.

The meeting was called to order May 3 by the newly elected President, Dr. W. S. Lindsay. Those present were the following: President Dr. W. S. Lindsay, Acting Secretary Dr. L. F. Barney, and Councilors Dr. J. A. Dillon, Dr. W. F. Sawhill, Dr. H. N. Moses, Dr. O. P. Davis, Dr. C. C. Goddard, Dr. P. S. Mitchell, Dr. C. S. Kenney, and Dr. D. R. Stoner.

The order of business was as follows:

The selection of a meeting place for the next annual meeting of the Kansas Medical Society. Ottawa was chosen.

Dr. W. F. Sawhill was elected a member of the Medical Defense Board to fill the place of Dr. K. P. Mason, who has gone into the Medical Reserve Corps.

The Secretary, Dr. L. F. Barney, gave a report of the meeting of the Secretaries

of the State Medical Societies, held at Chicago, April 30, 1918.

Dr. Davis moved that the editor's salary be increased to $1,200 per year. Motion seconded by Dr. Goddard and it carried unanimously.

It was moved and carried that the editor be empowered to employ all the additional help necessary to carry on the work of the Journal.

Meeting adjourned to meet at the call of the President.

———R———

State Nurses' Association.

The seventh annual meeting of the Kansas State Association of Nurses was held in Salina, May 15 and 16. There were seventy-five members in attendance.

The sentiment of those in attendance seemed to be in opposition to a reduction in any degree of the educational requirements for nurses. The Legislature will be asked to fix a standard three years' course for the training of nurses in this state.

Miss W. Pearl Martin, the secretary of the association, said in her report:

"The reason for the eternal shortage of nurses is because the life of a nurse is so short, usually estimated at seven to ten years. The life of a nurse should be just as long as the life of any business woman. The reason for her short period of usefulness is because she is run through the machine so hard. Her three-year course in training is the stiffest course any profession requires. After she is graduated and enters service she is called upon for continual sacrifice of sleep, recreation and oftentimes without proper food. We must have more nurses and we must raise our standards and give the nurses better care or the young women of today will refuse to enter the ranks of the finest profession there is.

"The government is calling for 3,000 Red Cross nurses. Kansas' quota is 445. At present there are only 131 Red Cross nurses in the state.

"We will probably make a survey for Red Cross nurses. I am sure Kansas will go over the top with its quota in this respect just as it has done with every other war relief enterprise..

"Kansas has 1,061 registered nurses, many of these, however, working in other states or who have gone into Red Cross work. There are thirty-five training schools in the state in which 525 girls are enrolled. In June 145 nurses will be graduated and will come to Topeka to take the state examination June 4-5. Practical nurses enrolled with the association number 854, first aid workers 860, and home nursing students 540.

"The following organizations concern themselves with nursing services, according to the report of the committee on nursing. Boards of education hiring nurses are Atchison, Topeka, Lawrence, El Dorado, Wichita, Wellington, Salina and Kansas University (2). Women's Clubs—Wichita and Hutchinson. Public health nurses—Topeka, 4; Pittsburg, 1. Social Service League — Lawrence, 1. Civic League—Dodge City, 1. Visiting Nurses' Association — Kansas City, Kansas, 3; Atchison, 2; Metropolitan Life Insurance Company, Wichita, 1. Oil companies—Butler Co., 3. County commissioners—Butler County, 1. Cities—Topeka, 1; Arkansas City, 1; Emporia, 1; Swift Packing Co., 1; Kansas City Canning Factory, 2; Kansas Association for the Study and Prevention of Tuberculosis, 1. Red Cross sanitary units—Leavenworth, 5; Manhattan and Fort Riley, 5. Ladies' auxiliary to hospital—Newton, 1. Total number of nurses in field, 46."

A Red Cross meeting was held Wednesday evening, 8 p.m., at the Lamer Annex, Mrs. O'Keefe presiding. The program consisted of a musical, an address, "Loyalty," by the Hon. C. W. Birch, Salina, and an address by the Hon. J. D. Houston of Wichita, "What the Allies Expect of the Profession." "The allies expect much of the American nurses," the speaker said, "America expects much of you and they will get it. If in the end of this struggle, disarmament of the nation follows, even the half of the armies be destroyed, the war will not have been in vain. Woman

suffrage and national prohibition will be two results of this world struggle, too." Miss Lyda Anderson of the Southwest Nursing Division has a forceful address showing the relation of nursing work to the present war. "The shortage of one nurse in a base hospital means the untold suffering of many men, and the nurses of Kansas should feel that each one of them is responsible, personally, should there exist anywhere on the front or in France such a shortage." This service is not an adventure or a pastime. It is war, and every American nurse owes her training to her country."

Thursday afternoon we had the pleasure of hearing Miss Elizabeth Shellabarger, a nurse from the army base hospital at Ft. Riley, who brought a most encouraging report as to the good care the government is giving to the nurses at Riley and of her own joy in this service.

The following instructive addresses were given during these sessions:

"How One Kansas Town Met Its Public Health Problem," by Mrs. Virginia Knox Kimble.

"What Is Being Done by the Chamber of Commerce to Help Win the War," by Mr. T. S. Jamieson, secretary of the Salina Chamber of Commerce.

"Nursing in Sweden Some Years Ago," by Mrs. Jennie Neilson Graf.

The Constitution and By-Laws were revised to meet certain requirements of the National Nurses' Association. Among the resolutions adopted were the following:

Resolution 3. Be it resolved that the legislative committee be instructed to introduce the following amendments:

a. That the period of instruction in the training schools shall be three full years.

b. This instruction to conform to the recommendations of the National Association of Nurses for standardization of curriculum of training schools.

c. That the committee work out an affiliation between the larger hospitals and those not meeting the requirements of the national organization.

d. That there should be at least two registered nurses resident in the hospital, one of whom may be Superintendent of Hospital and Training School.

e. That the registration fee be ten dollars.

f. That the word "twenty be stricken out and the word "eight" be substituted in Section 1, Act 1 of present Registration Law.

Resolution 4. That each member of this association consider herself a committee of one to use her influence with her own senator and representative to see that he help carry out such legislation in full and complete detail as our legislative committee submits.

It was also voted that there be added to the list of prices, recently issued by the association, the following provision: "That registered nurses must have six hours sleep and two hours recreation out of the twenty-four."

The following officers were elected for the ensuing year:

President, Sister Catherine Voth, Newton.

Vice President, Miss Pearl Laptad, Salina.

Secretary, Miss W. Pearl Martin, Topeka.

Treasurer, Miss Kate Williams, Hutchinson.

SOCIETY NOTES.

SHAWNEE COUNTY SOCIETY.

The June meeting of the Shawnee County Society was held in the Chamber of Commerce on the 3d. A special program was arranged for the dedication of a service flag in honor of those members who have entered military service.

Addresses were made by Justice Henry F. Mason, Adj. Gen. Chas. S. Huffman and Sister Catherine Voth. The flag is about three feet by six and contains at the present time twenty-two stars. Other stars will be added in the near future.

No meetings of the Society will be held until September.

STAFFORD COUNTY SOCIETY.

The Stafford County Medical Society met in St. John Wednesday, May 8, at 3 p.m. Members present, F. N. Tretbar, J. J. Tretbar, Stafford; F. Kerr, Radium; C. S. Adams, J. T. Scott, St. John.

J. T. Scott read a paper on Endocrinology which was discussed by all present.

J. T. SCOTT, Secretary.

BOOKS.

The Surgical Clinics of Chicago.

The Surgical Clinics of Chicago, Volume II, Number II (April, 1918). Octavo of 208 pages; 79 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper, $10; cloth, $14.

The Surgical Clinics seem to grow more and more interesting with each number. The April number is one of the exceptionally valuable ones. There are a number of clinics by the Chicago men on various subjects and they all come up to the usual high standard. One of the unusual subjects is discussed by Roy L. Moodie, Ph.D., and is "Pathologic Lesions Among Extinct Animals; a Study of the Evidences of Disease Millions of Years Ago." Lespinasse has a clinic on "Impotency: Its Treatment by Transplantation of Testicle." Porter also shows a very interesting clinic on "Tendoplasty for Paralytic Talipes Vulgaris."

The Way Out of War.

Notes on the Biology of the Subject, by Robert T. Morris, F.A.C.S., author of "Tomorrow's Topic Series." Published by Doubleday, Page & Company, New York.

This is another scientific analysis of the conditions underlying the present war—an idealistic conception of the biologic relationship between this war of great nations and primal cellular contests. He says: "The natural history of warfare, beginning with the primal contest between amœba and microbe, may be traced through all organic life, its demonstrations incidentally including the present war, and giving us a vista looking toward the nature of future wars. * * * Struggle is continuous through all phases of organic life. * * * All organic warfare is fundamentally enzymic in its processes, not only between the lower organisms which fight with their secreted enzymic poisons, but also among plants and animals, including man, man being activated in warfare by his enzymes."

Long Heads and Round Heads, or What's the Matter With Germany?

By William S. Sadler, M.D., professor at the Postgraduate Medical School of Chicago; director of the Chicago Therapeutic Institute. Published by A. C. McClurg & Co., Chicago. Price, $1.00.

This is an anthropologic analysis of the conditions leading up to the present great war. Some of the facts presented are very interesting as such, but taken altogether they do not seem to conclusively establish the responsibility of racial blending for this war. The great men of Germany, the military leaders, are of Nordic stock, while the rank and file is made up of inferior stock, but one must place responsibility upon the leaders rather than upon the masses.

One of the very interesting facts referred to by the author is that the Somme River and the territory adjacent thereto has probably been the battle ground of several prehistoric race conflicts.

He presents the attitude of the great writers, teachers and scientists of Germany upon the methods of warfare adopted by Germany. It seems almost incredible that men of such learning should prostitute their intelligence to promote the militaristic ideals of an ambitious ruler, but the quotations speak for themselves. Whether one is ready to accept the anthropologic factor in the war or not, the book is a very interesting one—very well worth reading.

Manual of Vital Function Testing Methods and Their Interpretations.

By Wilfred M. Barton, M.D., Associate Professor of Medicine, Medical Department, Georgetown University; attending physician to Georgetown University Hospital, Columbia Hospital and Washington Asylum Hospital. Second edition revised and enlarged. Published by Richard G. Badges, The Gorham Press, Boston. Price, $2.00.

The author has collected and arranged for convenient reference all of the important testing methods of the various vital

functions of the heart, liver, pancreas, kidneys and ductless glands. The technic of the various methods is carefully explained as well as the manner of interpretation.

The appearance of a second and revised edition of this work suggests that it has been well received and fully appreciated by the profession. We know of no other book covering this particular ground, although the need for something of the kind is very apparent.

Blood Transfusion Hemorrhage and the Anemias.

By Bertram M. Bernheim, A.B.,M.D.,F.A.C.G., Instructor in Clinical Surgery, the Johns Hopkins University; Captain, Medical Reserve Cops, U.S.A.; author of Surgery of the Vascular System, etc. Price, $5.00. Published by J. B. Lippincott Company, Philadelphia and London.

About five years ago the author published his book on Surgery of the Vascular system, which included a chapter on transfusion. In attempting to revise this chapter he found that the importance of transfusion and the literature upon the subject had grown to such proportions that he felt justified in preparing a new and complete text on that subject. It is discussed under the following heads: Blood and the Phenomenon of Bleeding; Diagnosis of Hemorrhage; Control of Hemorrhage; Dangers of Transfusion; Indications for Transfusion; Selection of Donor for Transfusion; Methods of Transfusion; Transfusion for Acute Hemorrhage and Shock; Transfusion for Anæmic and Debilitated Conditions in General; Blood Dosage; Primary Pernicious Anæmia; Transfusion for Hæmophilia; Malæna Neonatorum, Purpura, Jaundice; Leukemia; Splenic Anæmia; Certain Toxæmias.

The Spleen and Anemia.

Experimental and Clinical Studies, by Richard Mills Pearce, M.D., Sc.D., Professor of Research Medicine, with the assistance of Edward Bell Krumbhaar, M.D., Ph.D., Assistant Professor of Research Medicine, and Charles Harrison Frazier, M.D., Sc.D., Professor of Clinical Surgery, University of Pennsylvania. Sixteen illustrations, color and black and white. Price, $5.00. Published by J. B. Lippincott Company, Philadelphia and London.

This is a collection of very interesting studies on the spleen, showing its relation to blood destruction and regeneration, prefacing some further studies on certain therapeutic procedures in diseases of the spleen.

The subjects as they appear are: The History of the Extirpation of the Spleen; Regulatory Influence of the Spleen on Blood Destruction and Regeneration; Diversion of the Splenic Blood from the Liver without Removal of Spleen; Changes in the Bone-marrow after Splenectomy; Changes in the Liver and Lymph-nodes after Splenectomy; Metabolism Studies on the Dog Before and After Splenectomy; General Summary of Experimental Studies; Metabolism Studies on Man Before and After Splenectomy; Classification and Analysis of Types of Splenomegaly Accompanied by Anemia; Methods of Value in the Diagnosis and Prognosis of Splenic Disease; Treatment of Splenic Disease by Methods Other than Splenectomy; Value of Splenectomy as a Therapeutic Measure; The Surgical Treatment of Lesions of the Spleen.

MISCELLANEOUS.

Health Conservation a War-Time Necessity.

So many physicians have entered the army and navy service that it is becoming increasingly difficult for those who have the civilian population under their care to give them proper attention. The prevention of many diseases by prophylactic measures is therefore assuming greater proportions each day as the war continues. Smallpox and typhoid fever have been practically eliminated as army diseases, simply because their prophylactic treatment has been made a routine procedure. Typhoid can be eliminated from the civil population just as it has been eliminated in the army, and it is the duty of the physician to suggest to his patients that they protect themselves against epidemics of disease which can be avoided by proper prophylactic measures. In these days when every individual is needed to carry on the work of the large factories which are supplying our troops with the sinews of war, there should be as little

sickness as possible, not only because the production of war materials is retarded when skilled workers are unable to discharge their duties, but because it is fundamentally wrong to take up space in our hospitals and the time and energy of nurses and physicians with cases of diseases that can be prevented.

The time factor is an important one just now and those prophylactic agents which bring about immunity in the quickest possible time and with the least loss of energy should be given preference. It is fortunate therefore to have at hand sensitized bacterial vaccines which, according to Besredka and other authorities who have confirmed his findings, bring about an extremely rapid immunizing response—the immunity beginning twenty-four to forty-eight hours after the injection of the serobacterin. In the case of ordinary bacterins the immunity does not begin so rapidly and local and general reactions are more severe and prolonged. The value of typhoid immunization with a bacterial vaccine composed of a suspension of killed typhoid bacilli in physiological salt solution is unquestioned. The greater rapidity of bringing about immunity by using the sensitized vaccine or typho-serobacterin gives the latter product preference, especially at this time.

It is also particularly timely to mention that many sufferers from hay fever have been able to remain at their posts because of prompt prophylactic immunization with hay fever pollen extracts. The time for immunizing fall hay fever sufferers is at hand. Complete literature on typho-serobacterin and hay fever pollen extracts can be obtained from the H. K. Mulford Company of Philadelphia.

℞

Cotarnin.

Cotarnin is an artificial alkaloid derived by oxidation from narcotin, by a process analogous to the derivation of hydrastinin from hydrastin (which again differs from narcotin only by an additional OCH_3 group). Cotarnin hydrochlorid is marketed as stypticin, and cotarnin phthalate as styptol. Cotarnin is used systemically mainly against uterine hemorrhage, especially in menstrual hemorrhage, endometritis and congestive conditions. It is ineffective against postpartum hemorrhage or bleeding from gross anatomic lesions, and probably also against hemorrhage in other internal organs. Local application of cotarnin in substance or concentrated solution has a direct vasoconstricting effect and is used in tooth extractions, epistaxis, etc. (Jour. A.M.A., May 11, 1918, p. 1396.)

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New and Nonofficial Remedies.

Chlorcosane.—A liquid, chlorinated paraffin, containing its chlorine in stable (nonactive) combination. It is used as a solvent for dichloramine-T and is itself without therapeutic action.

Chlorcosane-Calco.—A brand of chlorcosane containing from 31 to 35 per cent of combined chlorine. The Calco Chemical Co., Bound Brook, N. J.

Chlorcosane-Monsanto. — A brand of chlorcosane containing from 27 to 30 per cent of combined chlorine. Monsanto Chemical Co., St. Louis, Mo. (Jour. A.M.A., May 18, 1918, p. 1459.)

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At the annual meeting in May, Dr. W. F. Sawhill, Concordia, Councilor for the Seventh District, was elected to a place on the Defense Board.

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WANTED—FOR SALE—ETC.

WANTED—South Central Kansas—competent physician for a $3,000 practice; collections good; population 500; one other physician; good farming community. "M," care Journal.

WANTED—Woman physician as assistant or partner. No objections to recent graduate. Address "Woman Gynecologist," care Journal.

FOR SALE—Established practice in good Kansas town for about half cost of office fixtures. $200, terms. Act quick. "H," care Journal.

FOR SALE—Central Kansas town, 650, main line Santa Fe. Beautiful eleven-room residence, bluegrass lawns, plenty of shade trees, fruit trees, cement walks, cement wash house, good garage, cement floor, good office furniture, at half price. One other doctor. Going to large town June 1. Good country around town. "Y," care Journal.

Arsphenamine.

No, this is not a new chemical; it is simply the name adopted by the Federal Trade Commission for the hydrochloride of 3-diamino-4-dihydroxy-1-arsenobenzene —in other words, salvarsan. The three firms which have been licensed to manufacture this drug are permitted to have their own trade names for it, but the official name "arspenamine" must be the prominent one on the label of all brands. Hence physicians should at once make it a point to learn and use the name "arsphenamine." (Jour. A. M. A., Jan. 19, 1918, p. 167.)

℞

American and English Income Taxes.

In comparison with the tax levied in England on incomes, our own income taxes are moderate indeed.

In England the tax on incomes of $1,000 is $4\frac{1}{2}$ per cent, in America nothing.

In England the tax on incomes of $1,500

Campbell

X-RAY
AND
High Frequency
Apparatus

Campbell X-Ray Apparatus has been used by the United States government almost exclusively for the past three years, the most notable single installation being that of the seven camp hospitals along the Mexican border last year.

At the Panama-Pacific International Exposition in San Fracisco, 1915, Campbell X-Ray and High Frequency Apparatus received the Medal of Honor, the highest award given any manufacturer of X-Ray apparatus.

At the last International Red Cross Conference, the Campbell Electric Company was the only manufacturer of X-Ray apparatus in America to receive an award. Seven nations were represented in the jury making the award.

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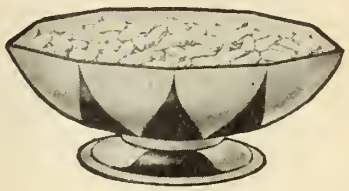
READ THIS CONTRACT

I herewith hand you the following accounts, which are correct, and which you may retain six months, with longer time for accounts under promise of payment. Commission on money paid to either party by any and all debtors is to be 40 per cent on amounts $5.00 and over, and 50 per cent on amounts under $5.00. Client agrees to report in writing to the Association on the first day of each month any money paid direct to client.

In consideration thereof, the Association agrees to strive persistently and intelligently to make these collections at no expense to the client and to issue statement on the twentieth day of each month, provided the Association has received report from the client.

REFERENCES: Southwest National Bank of Commerce, Missouri Savings Association Bank, Depositories, Bradstreets, or the Publishers of this Journal; thousands of satisfied clients everywhere. Attach above contract to your list and mail at once.

PUBLISHERS ADJUSTING ASSOCIATION, Railway Exchange Bldg.
Kansas City, Missouri, U.S.A. Medical Department, Desk A



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Puffed Rice — Corn Puffs
Puffed Wheat
Each 15c Except in Far West

Puffed Wheat and Puffed Rice are whole grains puffed in this way. Corn Puffs are pellets of hominy puffed to raindrop size.

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, JULY, 1918 No. 7

War Experiences in a German Base Hospital.

DR. H. M. RICHTER, Chicago.

Address before the Kansas Medical Society at Kansas City May 2.

My war experiences are entirely those of a base hospital. My own work was not at the front, so my personal experience with fresh work is nil. I was able to get material from the east front as well as from the west front, so that we, in our base hospital, could get a good trend of the German thought on the treatment of the wounded. The great masses of those brought to us had infected wounds and compound fractures. We received a small number of men with rifle wounds; also received a fair number of machine gun injuries, but in the neighborhood of 90 per cent, surely 80 per cent of those brought to us had compound fractures.

In order to understand the nature of our work you must understand the nature of shell fragment injuries. The rifle bullet, in military surgery, produces a clean wound, leaving a wound that heals kindly unless the bullet has been disturbed in its course. The shrapnel bullet is a round leaden bullet that usually remains in the tissues. The rifle bullet travels with great velocity and passes through the body, leaving the wound at its exit. The rifle bullet comes from a distance of 1,000 feet. The shell which explodes has come possibly a mile or two or three. The explosion of the shell causes the fragments to be irregular, and these fragments have rough edges, sometimes sharp, and other times dull. These fragments punch out the skin, carrying pieces of the clothing and skin into the wound. A shell fragment of considerable size tears away much of the tissues, shatters the bone, and carries away fragments of the bone, but the velocity isn't great enough to carry it on through. The bruising of the tissues results in infection.

In 1916 Germany was not using any means of disinfection. The wound was opened up very widely and packed with gauze without any idea of disinfection. Since that time a vast amount of literature has sprung up on the immediate treatment of wounds. Undoubtedly the most radical departure from the usual treatment of wounds has been the immediate excision of the wound. If you can excise the wound within a few hours of the time it is made (cutting out the hole, as it were), you can convert that wound into a wound which is analogous to a surgical wound.

The use of strong antiseptics never made any progress in Germany. I used iodin and plain faucet water, which was practically sterile. It was our finding that wherever we had adequate drainage for our infected wounds, we had good results.

There is very little gauze or cotton in Germany, so we used wood wool under the limb to allow the secretion to run into the pad. The wound was left wide open without the dressing. We found that the wounds did better without the dressing than with it. Patients with any kind of wound of ordinary size were dropped into the bath, and keep them there for several days and sometimes several weeks. They

were far more comfortable in the bath-tub than they would have been in bed.

In one of the earlier wars a part of the English army was cut off by the enemy and 500 were wounded. They were kept away from the main army for fifteen days. They had no dressing, no antiseptics, and only one surgeon. It was impossible to give attention to all of the wounded, so finally the men were allowed to do as they pleased. They bathed their wounds in the water of a near-by running brook. After fifteen days they got back to the main lines and found that the total morbidity and the total mortality of the little band away from the main army was far below the morbidity and the mortality of the others.

We strap the wounds with a piece of plaster or we suture them, following the work of Morrison on strapping compound fractures.

The bacteria on the surface of the wound have no bearing on the wound itself.

In the case of shell fragment injuries, the shell fragment should be removed at the earliest possible time after the patient reaches the base hospital. All of the fragments need not be removed—just those which are more than one-half inch in diameter. Our worst trouble was that we could not figure how to reach the fragments. There was just one way of locating them. We relied entirely upon the stereopticon X-ray work. Lead markers were placed at the point of entrance and then we had lead markers surrounding the wound, and in this way we were able to get a very beautiful stereopticon view of the wound.

The wide open treatment will do more toward localizing the infection. After five or six days these wounds become foul smelling and very disgusting, at this time we put the patient into the bath-tub. Then they are carried out into the yard with the wound wide open. We skin-grafted a few of the wounds, but this was done only occasionally.

Operation at the front is not thought advisable, or in other words it is what I call "guillotine operations."

Gas bacillus infection takes place mainly in the muscles. The treatment of gas bacillus infection consists of getting to the muscle and scooping out any muscle involved. This does not mean amputation.

Joint injuries are the most frightful of all, and are more destructive to life and limb. The mortality caused from compound fractures in the knee joints must have been close to 50 per cent. I looked up German literature on this, and according to that, it was easily 50 per cent. Good drainage is the great secret of success. No greater mistake could be made than to pack a wound with gauze to prevent draining.

The transportation of a patient with a fracture is a serious thing.

You may ask why we didn't have any cases of non-union. The reason is this: We made a clean incision into the skin and brought the wound together, and they would always unite. The bone is just the same as the other tissues—bring the edges in contact with each other, and they will unite. The danger of infection in the use of the fracture nail is very slight. Great care must be taken to keep the tissues from being separated. We had no results with operations or compound fractures.

War Experiences in a British Base Hospital in Northern France.

JAMES M. NEFF, M.D., Chicago.

Address before the Kansas Medical Society at Kansas City May 2.

I am going to give you some of my observations of the treatment of the wounded in a British base hospital in Northern France in the section of Ypres. The conditions were comparatively normal while I was there.

The first aid dressing stations were located in three places. The first, in the trenches; second, in the chateau behind the lines, and third, five or six miles behind the line. The wounded receive only the treatment which is absolutely necessary in these first aid dressing stations. If a man is wounded in the morning, he

is taken to the first aid station in the trench, he must stay there until night, for the trip to the next station must be made under cover of darkness. Therefore, a man who is wounded after daylight in the morning in summer must stay in the first aid station in the trench until about 9 o'clock at night.

The first aid stations consist merely in taking care of shrapnel and high explosive cases. They are treated with an alcoholic antiseptic dressing. Then a wooden splint is put on the patient and he is kept in the bunk until night. Then the Field Ambulance Corps provides an ambulance which goth from the first aid dressing station to the field ambulance station. Then they are taken to the casualty clearing station. The injuries caused by the shrapnel and the high explosives are all operated on at the casualty clearing station about 75 or 100 miles from the firing line. The percentage of recovery is from 50 to 60 per cent, which is a remarkable showing under the conditions. From the casualty clearing stations the ambulances take the patients to the various base hospitals. In the district where I was working there were between 65,000 and 75,000 patients divided among about thirty hospitals. Everything that is not done for the wounded at the other stations is done for them at the base hospital. They are kept in the base hospitals for three weeks, and in some cases for months.

When the patients first enter the hospital they are sent to their respective wards; next, we send all of the patients through the X-ray room, where the foreign body is accurately localized; then they are sent to the operating room and operated on at the earliest possible moment.

Compound fractures constitute the vast majority of all the cases brought to the hospital. There is one important point to bring out: There is practically no difference between civil and military surgery. Possibly the only difference is that treatment in military cases must be much more radical than in civil life. The reason for this is because of the peculiar type of injuries produced by the shrapnel and the high explosive shells; and also because we had to work with such rapidity.

Shrapnel fragments nearly always remain in the tissues. The pieces of metal which enter the body are multiple.

Another modification is because of the infective conditions. In military practice it is very different than it is in industrial practice. The soil of the country is very rich in bacterial origin. The clothing becomes contaminated with dirt, and when the force of the shell drives a part of the clothing into the wound it invariably causes infection.

The cases in which the greatest damage is done is when the bullet produces a larger wound of exit than of entrance. It keeps the wound of exit open and in contact with the clothing.

Another modification of military treatment is that the men are not in good condition to withstand infection or any form of disease. After they have been in the trenches for a few days, weeks or months, sometimes in damp and cold weather, sometimes standing in mud, and at other times undergoing great nervous strains, their resistance to infection and disease is diminished.

Sometimes the men are injured between trenches and lie there from twenty-four to thirty-six hours before they are brought to the first aid dressing station. This gives infection greater headway. The base hospital is the first point where they receive any real treatment.

The first three months of my service in France, the medical force was divided into three parts, each part receiving the same number of patients. Each doctor in the service had had free and adequate training and various methods of treatment were used. At the end of six months and again at the end of a year we compared results and found that they all had just about the same success. This brought up a very evident conclusion—that good, sufficient and adequate draining was the most important thing.

When the wounded arrived at the base

hospital, infection was nearly always under headway, the temperature was high, and the opening of the wound wasn't large enough to insure drainage.

In cases where the shrapnel fragment was imbedded within the tissue, we enlarge the wound of entrance, extract the metal, and cut away the margins of the skin wound, and clean out the cavity as well as we can mechanically. The sole treatment used was the irrigation of the wound with chlorine water. Chlorin water has been used for over a century in the treatment of infected wounds, not continuously, but occasionally. It is surprising to me that, during the course of the last century, the miraculous results of this solution was not discovered before the war.

If we can get the cases early, remove the clothing and put drainage tubes into the wound in the early stage, the great majority of the men will get well without infection. The surface bacteria have very little to do with the infection within the cavity or the lining of the shrapnel wound. It is the bacteria within the tissues that do the damage.

At first we had the idea that we should not put a tube into the joint in joint fractures. We lost all of those cases, and the men died.

Hot dressings in compound fractures are very valuable. First, they help to allay the pain, and second, to facilitate drainage. If the wound didn't yield to persistent drainage treatment, we would then resort to the enlargement of the wound.

During periods of great activity as many as 700 or 800 patients would be brought in in one night; however, the average number of patients per night was between 300 and 350.

A large number of the men brought in had gunshot wounds in the head. We were supposed to get treatment to these as rapidly as possible. They were sent to the operating room, the scalp shaved, and the skull exposed with the bullet hole in the center. Then they were examined to see whether there was a blood clot. If there was, it would be turned out immediately. The painting of the entrance of the wound with iodin saved a great majority of sun-shot wounds in the head. We treated them in this way because we didn't have time to do otherwise.

We thought that all of the fragments had to be removed in cases of shrapnel wounds in the brain. It seemed to be terrible to leave them in. In trying to remove the fragments we did more harm than good, because it meant the destroying of too much brain tissue, as we had to work so rapidly. In taking care of these wounds we followed Sargent's suggestion—we located them very accurately, enlarged the wound, and inserted a tube of glass or rubber, where there were signs of infection. What was done after that depended upon the conditions present. We removed the tube after a certain time, and many of them healed up.

We had several cases of patients with shrapnel wounds in the neck. Here is another important point—you can't place too much dependence upon what the average soldier wounded in the trenches says regarding the accident, because of the excitement and the nervous strain he has undergone. In cases of shrapnel wounds in the neck, they seemed all right until the shrapnel fragment was removed, and as soon as this was done the patient would have a hemorrhage, and it was evident that the piece of shrapnel was plugging the artery. A bullet many times injures the esophagus, the trachea or the larynx. During the time I was there we had only one wound of the heart, and in this case there was a small piece of shrapnel in the left ventricle. We had 150 gun-shot wounds of the chest. In cases of this kind nearly all of the patients had hemorrhages.

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The Needs of the Medical Corps.

JABEZ N. JACKSON, M.D., Kansas City, Missouri.

Address before the Kansas Medical Society at Kansas City May 2.

This is a subject with which we are all more or less familiar. As a member of the Medical Board, I may be able to say

some things that all of you may not know.

We are in the greatest war the world has ever known. It is making a greater demand upon the resources of the country and upon the medical profession than some of us are able to comprehend. We have never had a war lige this where there were such a great number of men involved, and where there were such important issues at stake.

At the beginning of the war we thought of it as a war between the European nations. We, as Americans, had little interest in it, not thinking that it would ever affect us.

This is not only a war between Autocracy and Democracy, but a war for the rights of individuals as well as nations. Even in this country there is an autocracy between the wealthy man and the common man. The rights of the common man to have an expression in the control of his own life and as an individual is an important issue of today.

At the beginning of this war I was a pro-German. Because of the sense of obligation we, as medical men, have had for the way Germany has contributed to the medical science, we always stood by her, but with the democracy of the world at issue, as it is today, no true American has any doubt as to his position.

None of us seem to realize what this is going to mean to the medical men of today. I happened to have the privilege of being in the Spanish-American service. I was given charge of a divisional hospital. No attention was paid to the recommendations of the medical men. The great danger to Americans at that time was the prevalence of typhoid fever among the men. Typhoid fever killed thousands of men, while bullets killed practically none. It was said that this was caused because of the ineffectiveness of the medical department, but it was not true, for the physicians at that time knew as much about the treatment of typhoid fever as they know today. Shortly before I left the service I was shown a stack of recommendations issued by medical men from the office—recommendations, not a one of which had ever been observed or enforced.

Our regiment pitched their tents on one side of a hill. Down in the valley they were a number of concessions where they sold ice cream, circus lemonade, and pies like mother didn't make. The men bought all of their knick-knacks at these places. Soon almost all of those frequenting these places were affected with some form of intestinal trouble and would get up in the middle of the night and chase to the valley for defecation. There was a little stream in the valley, the banks of which were grown over with a dense entanglement of willows, which afforded ample opportunity for the extension of typhoid germs. This stream ran past the place where the milk supply of the camp was obtained.

I requested that a force of men be employed to clean out the underbrush. I said something about this every other day, but it was never carried into effect. This will give you some idea of how the medical men stood at that time.

We had to learn a lesson from the Japanese in the Russian-Japanese War. When the Japanese troops went into camp, every drop of the water had to be passed upon. Any officer failing to do his duty in this respect was court-martialed and penalized. From this lesson, led preliminarily, the order that the medical men must have authority in their department to enforce regulations.

The range of the medical profession has not been increased. Neither has their authority been increased. I would say that each and every member of Congress should strive to have the Owen Bill passed, not only to give the medical men authority, but to bestow upon them a vested commission. Each member of the Medical Society of the State of Kansas should make it his duty to demand the passage of this bill.

The nation is asking all of her young men between the ages of 21 and 31 to serve by draft. Among the maturer men they are not requisitioning lawyers, grocers or bankers, but they are calling upon the men of the medical profession to leave

their practices, which they have spent many years of hard work to obtain; to leave their homes and loved ones and to give up their entire future. The important fact that the people of the United States are realizing is that the most necessary men in the community are the doctors. The medical profession is a dignified one, and it will stand as such more in the future than in the past, with such a great demand upon the doctor as there is today.

The Government is asking that they have one doctor for every hundred men. This means that 18,000 more doctors are needed at once. Day before yesterday a new bill was introduced calling for one and one-half millions at the least, and 5,000,000 as a maximum number. This will mean that there will be a need of 50,000 additional medical men. There are 15,000 men in the Medical Reserve Corps. We are confronted with the fact that as many more men will be needed within a very short time.

We must decide how we are going to meet this demand for this number. There are 100,000 doctors in America. Out of this number there are 80,000 men who are educated enough and capable to take a place in this work. This means that at least half of the doctors have got to be called on for service. Now then, what is going to be done by the medical profession to meet this responsibility?

The probability is that those men who are keen patriots have mostly all gotten in, and the additional number of doctors needed will have to be taken from those who will have to make a considerable sacrifice. I hope that we can have all of the doctors needed by pure voluntary response. I hope the doctors of America can voluntarily give up their practice and make sacrifices.

In order to meet the responsibility, we have been called upon to make an accurate census of all of the doctors; also classifying each man where he belongs.

I am going to tell you how we are taking care of this in Kansas City, Missouri. We sent out a bunch of questionnaires to all of the doctors in the city of all kinds. The questions included all the information asked when applying in the Medical Reserve Corps; also information regarding the man's obligations to his family, the number of dependents he had, and his capacity financially.

In the first class we placed the surgeons between the ages of 40 and 55, who have had a pretty extensive surgical experience. In the second class are the men between the ages of 35 and 45 who have served an apprenticeship but have passed the experimental stage. In the third class are the men who have had good educational training. Class 1, figuratively speaking, may be classed as the bachelor class; Class 2, as the man who is wealthy; Class 3, a doctor who has three or four children between the ages of 16 and 25, who are able to earn their own way, or at least to help to maintain themselves, and Class 4 will contain the doctors with four or five children between 6 and 12, and are absolutely dependent upon the income from his practice. We selected five of our leading men —men who were broad enough to make the right sort of classification, and to be absolutely fair in their decisions. This classification will be a wonderful help to the government, as they can tell where the resources of the medical profession are, and just what men should be called, and the order in which they should be called.

It is up to you to respond or not to respond. You are either a patriot or a slacker, without any question.

I am frank to say that I have always been an idealist or an "ultimate optimist." It makes no difference how d— bad things may seem, they are bound to be all right in the end. Things may be in a h— of a shape, but everything will finally come out all right.

The only difficulty in the moral draft is the need of quickness in getting ready. The time has come when every able-bodied doctor who can serve, should make application in the Medical Corps, and make it now! Those who have not been rejected

should put in their application at once! We should at least show that we are thorough American patriots from the bottom to the top. We trust to your sense of justice to do what is right in your obligation to the medical profession and to the Government. Let us spare those to the last who have to make the biggest sacrifice. Do your part in the preservation of the lives of these young men who have gone to the front to fight for Democracy.

I realize that the problem of serving is a very serious problem, especially if it means the sacrificing of a whole career. When a man goes out to serve our boys, he has practically offered the services of his life. At the age of 58 it is pretty late in life for a man to start over again. The man who has to do that has sacrificed as much as the young man who has offered his life and served in the trenches.

Some of you are saying, "Oh, I can't go, because if I leave, my competitor will take up my work, and when I get back I won't have any practice, for he will have taken all of my patients." Let me tell you something! The man who is going to have the business when the war is over will be the man who proves himself to be a patriot during this critical time. The man who has proven his manhood—that's the man who is going to be the best man in the social and professional world. The country is going to be absolutely controlled by the boys who are serving in the trenches. Some of you are old enough to remember the experience of the men who had served in the Civil War—those were the men who controlled the destinies.

Therefore, the young man under 45 who declines or hesitates to offer his services is making a great mistake. The time has come for the medical profession to prove to the world that it is a profession whose principles are to serve.

There are some features about the war that are not bad. A man of ambition wants to show his capacity of brain or muscle, and the war has given us that opportunity.

A man starts into business in a little corner grocery, with a few hundred dollars capital. In a year or so he builds a larger store and enlarges his capital. The first thing you know he has a capital of $1,000, and the next thing you hear is that he has a $10,000 capital. Then after a while he has a $100,000 capital, and later on a $1,000,000, and his success was inevitably marked by the dollar mark. He wanted to acquire success.

The lesson of war is not acquisition. The question is how much a man can put into the service, and not how much he can get out of it. The young man who goes out into the draft is offered as a sacrifice and not for the purpose of acquisition. The greatest thing on earth is the privilege that a man has of serving. The man who is giving himself to the nation is giving all that he has.

The best doctors in the country have no ambition to get rich. There is no night too dark and no storm too terrific for him to answer the call of the wounded and suffering.

I hope that we will prove now, as in the past, that the medical profession stands ready to offer its entire body of men if necessary. I hope the medical men of Kansas will offer themselves for service and have something which they can be proud of in the future.

Discussion No. 1—Dr. Liggett:

I would like to ask why the Government needs one doctor for every 100 men, when in civil life there is only one doctor among four or five hundred people.

Discussion No. 2:

What are we going to do with our civil population? In some communities most of the doctors will come under the moral draft law, leaving the civil population with no one to care for them. Why couldn't the Government pick up some of the older men and put them in the places left vacant by the younger ones? Distribute the doctors not in the service, among the people, so that no county, city or town will be left without a reasonable amount of medical aid. I think it would be a good plan to draft the men and send them away from

their homes to new communities. It seems that this would be a better plan than the one they have in England, where all of the sickness is brought to the hospitals.

Discussion No. 3:

What kind of physicians are being called? Are they asking for osteopaths?

Discussion No. 4—Dr. Blaisdell:

The medical profession of Reno County has been deeply interested in this subject which Dr. Jackson has been telling us about. There are three men in our town who are due now, and we have a half dozen men that could be spared if they felt that personal obligations were not in the way. There is one doctor in our town who is considering this more than anyone else. He has a wife and two children, and he is debating the question whether he can go and still support his wife and babies out of the salary he would get. As to the civilian population—I say, let the osteopath and the chiropractor take care of that.

Discussion No. 5—Dr. Dugan:

If the Owen Bill doesn't go through, those who serve will be badly handicapped in their provision of those who are dependent upon them. I would like to ask if there are any suggestions as to any way we can help to push the Owen Bill through.

Discussion No. 6—Dr. Deever:

I would like to ask what are the requirements for the volunteer corps, and what is meant by service. I am ready to go and serve anywhere.

Discussion No. 7—Dr. Crumbine:

I want to emphasize what Dr. Liggett said. There are already three counties without physicians. Due consideration must be made for the civilian population. We must consider the needs of the people left at home.

Discussion Closed—Dr. Jackson:

What are we going to do with the chiropractors? That belongs to the state legislatures. I trust and believe that when the medical profession has shown that it is patriotic, that the legislators will show themselves to be patriots.

As to taking care of the civilian population, that is the object of the classification list. We want to find out where the available ones are. If there are two adjoining towns, with four doctors each, two should be taken from each one, instead of all four in one town volunteering and leaving, and all four staying at home in the other town. The classification will enable the Government to know where the men are that ought to serve, and it will also help to get the right men and to preserve the rights of the people.

The kind of doctors taken—We have taken in eclectics and homeopaths, but up to the present time no osteopaths have been taken, unless he had a degree of medicine in addition. We had one chiropodist who asked us to commission him, because he said that there ought to be some one to take care of the feet of the soldiers.

This is how the Volunteer Corps started. There are lots of men willing to sacrifice their last drop of blood. In Philadelphia Dr. Davis and a few others who had passed the age got together and came to this conclusion. They said, "The Government won't take us in, so we are going to organize something to get ourselves in."

We are taking no men into the Reserve Corps who are not capable of rendering any military service they may be called upon for. I believe the right thing will be done in the right way. There is something for everyone to do. Everything must be worked so that men will be placed where they can serve to the very best advantage. It wouldn't do to put a man with heart trouble into the trenches. It would be of no use to send the medical profession to Camp Funston to do surgical work. We must find service somewhere where we can do our duty.

The Medical Reserve Corps is a new organization, the details of which have not been worked out. It is not to be a refuge for slackers. You cannot enter the voluntary corps unless you have first volunteered and have been rejected. They have a service badge which shows that he has vol-

unteered and offered to do whatever he can.

Regarding the Owen Bill—we can do a great deal right here to help secure the passage of this bill. Each one of us is thinking, "What would my Senator care for *my* telegram?" But I can tell you one thing, that is: If 300 doctors would send telegrams to the Senators of Kansas urging the passage of this bill, they would know that they meant to do something.

The medical profession is furnishing more finished ability than there is in the whole army. Sometimes a certain man will be pointed out and you will say, "That man ought to be a major." Your ability as a civilian doctor is a small part compared with your ability as a military doctor. They don't know anything about your military capacity. You enter a training school, and there the men are prepared physically. A doctor sticks in a hospital or in his office, rides in a buggy or an auto, and becomes soft. He has got to be in good physical condition just the same as the boys who are in the trenches. This training school puts him in a good physical condition. Then the experts get a chance to find out what you are best fitted for. A young fellow, 27 years old, was given charge of a hospital, and they soon learned that he was a wizard, and they made him a major. If you have ability and knowledge, don't bother about your standing when you first go into the service.

The Government pays the doctor $2,000 per year. There are very few young men in the practice that net more than the Government pays them. It is the older men with the big incomes who are going to have to make the biggest sacrifices.

The Training of the Civilian Physician for Army Service.

Col. W. N. Bispham, M.C., M.O.T.C.,
Fort Riley, Kansas.

Address before the Kansas Medical Society at Kansas City May 2.

In the past wars of this country, one of the greatest defects in our army administration has been the injection into the medical service of many absolutely untrained physicians. By that I do not mean that they were professionally disqualified, but that they were profoundly ignorant of the duties an officer is called upon to perform and also of the relation of the Medical Department to the rest of the army.

In the Revolutionary War and in the War of 1812 there was practically no medical service worthy of the name. The armies of these periods melted before the advance of communicable diseases. This condition of affairs was duplicated in the Mexican War.

In the Civil War, when the Federal Army was organized, the proportion of civil physicians brought into the service was even greater than it is at the present time. They did what they could, but without prior training they had slight knowledge of their duties. For example: At the first battle of Bull Run the medical director of the army occupied himself with administering first aid to the wounded — duty which should have been performed by the regimental medical service. The supervision of the care and evacuation of the wounded received no attention, thereby causing great suffering among the same wounded. It was only after the war had lasted for a couple of years that Surgeon Jonathan Letterman, who had appreciated the defects of the service, was able to have adopted his plan for the proper handling of the sick and wounded of the armies. It may be said in passing that this plan, with certain modifications, is the basis of the medical service of all armies in the field at the present time.

Furthermore, during the Civil War, absenteeism was very prevalent. This absenteeism was materially promoted by the action of medical officers of the army, who persisted in treating the sick and wounded as they would their private patients and, though the individual benefited in most cases, still large numbers of men who had entirely recovered and should have been doing duty with their commands, were at home far from the battle line. When you consider the fact that at the battle of

Antietam, where the Confederate forces were checked, only one-half of the men belonging to the Federal Army were present with their regiments on that day, you can imagine what would have happened to the Confederate Army if the large number of able-bodied absentees had been returned to their command before the engagement began.

The Spanish-American War was fought so short a time ago that many in this audience have vivid recollections of the terrible failure of the medical department at that time.

At the beginning of this war the previous failures of the medical department had impressed themselves upon our present War Department to such an extent that steps were immediately taken to eliminate these prior defects and build up a medical department which would be not only efficient, but also a credit to the nation. The lack of military training of the civil physician received the first attention, and training camps to give this military training were established at Fort Riley, Kansas, Fort Benjamin Harrison, Indiana, and Fort Oglethorpe, Georgia. Carefully selected regular officers were sent to these several camps to immediately institute the training of large numbers of physicians, who were sent there for the purpose. This training was to be carried out for the space of three months and then the medical officers would be sent to divisions, base hospitals, etc., to take up the duties for which they entered the service.

The training, as outlined, started with two main objects in view. First, the instruction of the civil physician in discipline and, second, the provision of a groundwork of military procedure, army regulations, etc., upon which could be built a finished medical officer when he reported to his future assignment. It can be readily understood that when the handling of many sick and wounded in a very short time is considered, the instant and willing obedience to orders given by those in authority in the medical department is essential. There are always two objects uppermost in the mind of the medical officer. First, that every effort must be given to the maintenance of the fighting force at its highest state of physical efficiency and the rapid return of the disabled to the firing line. Second, the perfection of the care of the sick and wounded to such an extent that the least amount of suffering is present. These objects can never be attained unless the officers and men are well disciplined and respond promptly to all instructions given, and not only promptly, but with a willingness which eliminates all consideration of self. This discipline is accentuated at the camps and becomes the main underlying feature of all instruction.

All of you who are familiar with the service in France, whether by actual observation or by the reading of the reports of those who have been engaged, appreciate the fact that the amount of physical exertion and the expenditure of energy in every department is so great that the physically defective or the physically undeveloped man is so handicapped that his services are not only of little value but frequently of detriment to the army. Therefore, special instruction of the doctor, who, ninety-nine times out of a hundred, has led a sedentary life, becomes a prominent feature at these camps. Instruction, though, of such a graduated character is given that there is no danger of a too rapid development causing dilatation of the heart and other complaints. For instance, with all officers of forty years of age and upward, careful instruction is given at the gymnasium under a well-trained physical director, assisted by a cardio-vascular expert. After service here at this camp you can readily pick from a collection of officers those who have been through this physical instruction.

Naturally, in all army administration, there are certain regulations more or less elaborate, certain papers necessarily to be made out at intervals, and those regulations and papers are unknown quantities to the new medical officer. In the early weeks of his instruction a great deal of stress

is placed upon instruction along these lines so that when he gets to the actual performance of such duties he is familiar with the work and he not only can make the proper decisions and complete the proper papers, but will have more time to devote to the real work in hand, which is, of course, the care and handling of the sick and wounded. As the course progresses at these camps, the officer is shown all of the workings of the medical department and his instruction is arranged in such a way that if he should be assigned to duty in almost any department, he would be, to a certain extent, familiar with the methods used in this department.

This basic course, as we call it, must be taken by all officers, but some are required to take only a portion of it. These are officers who are especially fitted for work along professional lines in base hospitals, etc. To further this instruction of a professional nature, several schools have been formed which give professional instruction. These schools are a part of the regular course at all training camps. For instance: We have a course in X-ray, Orthopedics, and Surgical Technique. These courses provide for a certain amount of instruction in army regulations, etc., but the major portion of the work of the classes is put into professional instruction in their particular line. These courses do not last for three months, but only two, and the last month is almost entirely professional. The success of these courses has been marked and officers who have been graduated and sent to perform this special work in base hospitals have been found much better qualified than the men who have come direct from civil life to the hospitals. These courses are conducted by specialists who not only have national reputation in their special work, but also have been teaching this work for years at some of the most prominent medical schools in the country. It may be stated that if it is possible to keep the officers assigned to these special courses longer than two months, they are given practical instruction at the base hospitals situated close by the several camps.

There is also connected with the camp at Fort Riley a department which is organized to give thorough instruction to sanitary inspectors and men who will do more or less sanitary work with the troops in the field. This instruction is not only didactic, but is very largely practical in character. An officer, if found to be qualified to do this type of work, is required to make inspection of the training camp and also of the camp at Funston under a trained sanitary inspector. He is also required to make studies of the finer points of sanitary work such as water supply, sewage disposal, etc.

Another department closely related to that of sanitation is the department of epidemiology. All of you are familiar with the great importance of this subject; particularly, you know that when you bring large numbers of young men from farms and other more or less extra-urban pursuits, all together in barracks, measles, mumps, scarlet fever, etc., are bound to occur, and what the army should do is to limit the spread of these infections when they do occur. The average physician does not understand this type of work as he has never engaged in it. Therefore this department of epidemiology is constituted to give this average physician such instruction that he will know what to do in the combating of these communicable diseases and limit their spread to the very smallest degree possible.

This, then, is the outline of the instruction of the medical officer. You can readily see, though, that this instruction would be of little value if it was carried on in a special school far away from the military life and the military organization. Therefore, the camp at Riley and also the one at Oglethorpe is arranged for the organization and training of the enlisted force of the medical department. We have there at present ambulance companies, field hospitals, evacuation hospitals and all other organizations that are necessary for the care of the sick and wounded. The officers in training come in contact with these or-

ganizations and are assigned to them for training purposes so that they are thoroughly familiar with the work which is required of these different units. They are also familiar with the handling of enlisted men, who will be required to do the actual labor of nursing and handling of the sick and wounded all along the line.

Now, what has been the result of all of this expense, time and trouble? Has it been justified, or have we made a failure? Gentlemen: Take the situation as it exists today. Visit camp after camp, hospital after hospital, and you will find that the man, regardless of his location, who is doing the best work in all of these places, is the man who has had the training at the training camps. He has more confidence, more knowledge of military procedure, more knowledge of the soldier, and, furthermore, his discipline has been ingrained into his being. Take two men, both professionally equal, and the superiority of the training camp graduate is so marked that he appears to be mentally a much abler man than his untrained confrere.

We feel that we have been successful, but much more than a visible success in the training of the officers, we have built up for the medical department of the army an esprit which holds us together in one great body; all working not for selfish ends, but for the efficiency of the medical department and to do our best in assisting our Government to bring this war to a successful end.

Organization and Fraternity.

J. W. HELTON, M.D., Hillsdale, Kan.

Read before the Miami County Medical Society, May 31, 1918.

Having been asked a number of times to write a paper for this Society, and having at a recent meeting been honored with the office of president, I take this opportunity to thank you, and have tried to formulate a few thoughts on organization and fraternity.

While organization is necessary to the standing and advancement of our science and teaching, fraternity is necessary as well to the more intimate and friendly relationship of the profession, and the closer blending of our lives together socially.

I believe there is no word which means more when properly applied, and properly followed, than does that of fraternity. It is the one word that binds together, or should bind together, the entire profession, in one great bundle of loyalty and friendship.

It is indeed unfortunate that the real fraternity of our preceptors and predecessors is on the decline, and we are becoming more and more absorbed in self and selfish ends.

One of the hardest struggles for the medical man, and the one so often overlooked, neglected and uncultivated, is the effort to abolish selfishness and prejudice among the profession and in our own lives.

How much easier and more natural it is to see the weak places in others than to look deeply into our own life and purpose, and see the lingering anxiety to gain at the expense of others, or to build our own castle of hope upon another's downfall.

It is not necessary that one should fail in order that another succeed. But we should go hand in hand toward raising the medical standard, breaking down professional strife and jealousy, and helping to make each other better, safer, and more useful to the public.

Organization is not only essential to our own interest and welfare, but for the interest and protection of the public as well.

It is not our purpose to slander, scold or criticize, but to call the attention of this Society to the fact that, even in this day of advancement in the science of medicine and surgery, our states, counties and cities are traversed and populated by so-called doctors, who are not only swindling and robbing the people with no regard to the alleviation of pain or cure of disease, but are dishonoring, disregarding and disgracing the medical profession.

I have only to call attention to a few

points along this line and you will doubtless agree with me that we have great need of a stronger and more thorough organization of the medical profession, in fact as well as in form, not the mere mechanical routine of membership in a district, state or national society, whose meetings we seldom if ever attend, and of whose actions we are careless and unconcerned, but the coming in closer contact and sympathy with our fellow practitioner; the real unanimity of heart and hand in the great work that is ours to do, and the great battles that are ours to fight.

There is no class of people who have done more, and who have more to do for the benefit and protection of the human family, than has that of the medical profession, and no profession whose work is accepted more ungratefully and whose actions are more carelessly and wrongfully criticised than is that of ours.

Even now, as we meet together in an effort to revive and try to place on a better working basis our county society, that the most vital interests of our community and the standing and advancement of our profession may be promoted and protected, there are those who are so ungrateful and selfish that they would brand us as thieves and robbers, met for the purpose of organizing against the people to advance our fees or collect our bills.

We might state here that the attitude of the public toward medical societies, and the lack of confidence and respect for the work they have done and are doing, is often augmented and encouraged by a few selfish grunty practitioners, claiming to be professional men, who grasp the apparent opportunity to better their own standing by creating a prejudice against medical societies and their members.

Think of the entire medical fraternity as being of the same selfish nature and wonder what strides our science would make in the future.

The real motive and purpose of medical societies, whether district, state or county. should be the interest and protection of the people, and fraternity alike. And as the interests of the people are best protected through the ability and energy and skill of their physicians, any benefit we may derive from these meetings, individually or collectively, goes directly to the people, through their representative members.

If we limit the spread of contagious and infectious diseases, we narrow our own field of labor that life and health may be more safely guarded and the sanitary conditions of our country bettered.

If we stamp out of existence the damnable and dangerous practice of speck peddlers, so-called eye specialists, nose and throat specialists, aurists, and "general" specialists, who are out of legitimate employment and seek to swell their bank accounts by traveling over the country, misleading, misrepresenting and preying upon the honest people who are enfeebled in body and mind, we may save their eyes and health and money, and teach them to consult their family physician, who should be able to send them to the proper specialist.

If we set our feet upon the Peruna bottle, our influence and votes against the Peruna congressman, and give our advice to the Peruna editor, we may save many people from the liquor habit and rob even temperance leaders of their favorite prescription.

If we expose the ignorance and misrepresentations of Eddyism, advertising quacks, and leg pullers, we create a stimulus among the thinking public to consider the class of people who study and follow these deceptive practices.

We desire to state in this connection that we have the utmost regard for the legitimate specialist who limits his practice to and qualifies himself for a particular branch of the medical science, and believe he should have the support and encouragement of our society and the general practitioner; but on the other hand we should show no quarter to the man, styling himself and advertising himself a specialist, who will cultivate a clientele in every disease or injury known in the

nomenclature of medicine and surgery.

I believe that patent medicines and their influence on health and society should receive our most careful consideration.

You must agree with me that hundreds of people are taking in patent medicines that which is expressly contraindicated in their peculiar conditions; and this is not all. Appetites are created and habits acquired for intoxicants and narcotics, even in the most earnest, faithful and temperate Christian families.

Pardon me when I tell you that it frequently finds its way into Christian homes and gains their unmerited confidence, from the simple fact of its mention and indorsement in religious periodicals.

How often do we read:

"A Prominent Minister Saved by Peruna"—twenty-eight and one-half per cent, or nearly one-third, alcohol.

"Physicians Fail. Lydia Pinkham's Vegetable Compound Saves from the Grave"—twenty and one-half per cent, or over one-fifth alcohol.

We might mention further that this preparation is highly recommended by the Women's Christian Temperance Union.

"We Cure Bright's Disease"—a claim for Warner's Safe Tonic, containing thirty-five per cent, or over one-third alcohol, which you know is expressly contraindicated in the above conditions.

Another preparation frequently found upon the covers of Sunday School and Church journals and highly praised by Women's Clubs and similar organizations, is "Parker's Spring Tonic," claimed to be a purely vegetable compound and which analysis shows to contain over forty per cent, or nearly one-half alcohol.

And so we find in nearly all these "tonics," "cures" and "soothing remedies" morphine, cocaine, and alcohol in varying percentages the exactness of which is possibly known, but probably not known even by their authors and makers.

I believe we should educate the people against traveling and local quacks of every class and description. From the so-called eye specialists traveling over the country with a ten-cent glass in a shining frame, warranted to cure the most aggravated case of astigmatism, to the deceptive teaching of the leg puller, or mind reader, one claiming that all diseases originate in the bones, the other that they do not exist at all.

Think of a half-witted self-conceited man-shaped creature claiming to be an eye specialist, who has never seen a medical school or read a medical book, advising people of the great importance of the ocular organ and the danger incurred by trusting the advice of the local physician.

Think of a man billing a town like a theatrical troupe, or magic lantern show, advertising himself as a "General Specialist," a specialist in every line of the medical science, claiming to cure consumption in sixty days, or chronic granulated lids in from fifteen to twenty, regardless of its standing or severity.

Think of a class of men spending three or four weeks in a first class school of deception and claiming to cure all manner of disease, without medicine, and remove abdominal, uterine and other tumors, of any size, shape or class, without the knife and without danger or pain.

And again, I regret to say, we are not without traitors even in our own camp. Doctor "A" is called to see a case which Doctor "B" has diagnosed as scarlet fever, and startles the family and community by the assurance that it is not scarlet fever at all, but simply a case of scarlatina. The family, not knowing the similarity of the two terms and the latter having a milder tone, is easily prejudiced against Doctor "B," who has made the proper diagnosis and taken the proper measure to protect the public.

This, of course, was in the absence of Doctor "B." In his presence no doubt he would have wilted like a flower before the noonday sun, or trembled like an aspen leaf in a June gale of wind.

I believe our individual and united efforts should be made to the end that this and every form of quackery may be disclosed and abolished.

I believe a great many wrong impressions and misunderstandings among the people are due to the fact that we are too often misleading in our statements. We should reserve the use of scientific language for scientific men, and as far as practicable use common terms before the common people.

I believe we should take more interest in matters pertaining to legislation and the election of legislators; that we should not stand idly by while laws are being framed and enacted which hinder and cripple the practice of our profession and the advancement of our science. We should be especially active at the present time in pending legislation which so vitally effects those of our profession who have responded to our country's call. These men have made a great sacrifice and deserve our loyalty and support.

I believe that a great deal has been accomplished and is being accomplished through organization; that the very nucleus and working center of organizations is the county society; and that the life and spirit of the county society is its secretary.

I trust we may all work hand in hand with him in an effort to make every legitimate physician of Miami County an active working member of this society.

———R———

War's Aftermath—Legitimate Surgery.

FRANCES A. HARPER, M.D., Pittsburg, Kansas.

Time was when a man doing a plodding general practice for years began to realize that life was being gradually drawn out of him by long hours and short fees. His brother surgeon, with his shorter hours and fatter fees, was a temptation not always to be resisted; so he hies him away to some great surgical center for a month or two of "specializing," returns and sets up as a "surgeon specialist."

For years he had been accumulating, and had on his list a fine lot of "chronics"—principally women—unfortunately the easiest prey of the would-be "surgeon specialist." He even had a long waiting list to be operated upon when he should return a full-fledged surgeon.

In this great world war, now raging, everything in the way of scientific discovery and invention is now being used to kill men! Has this horrible thing become necessary in order to save the women and children of the race? Legitimate surgery has saved many, and will save more, but illegitimate surgery has killed more women and children (in embryo) than famine, pestilence or war!

After the war, with its multitudes of crippled and maimed, surgery will hold a bigger meaning than ever before. Surgery must and will act along different lines—for the race must be conserved!

The man who makes a business of "trimming up women," as he facetiously terms it, should get a job on some well-regulated farm, where his pruning propensities might have free play, and perhaps have the opposite and less deleterious effect from that produced by his unsexing of women.

This war is going to change nations and peoples in many ways. Propagation and conservation of the race will have become a real necessity and real babies will again become fashionable—instead of cats and lapdogs—and large families will be the rule.

This pruner of women—this desecrator of motherhood—must either change his tactics or hie him away to the woods, where his efforts may be expended to better advantage with less danger to the human race.

Conservation of the race is only possible by conserving the pelvic organs of women. Disabled pelvic organs have heretofore been looked upon and treated as so much dead tissue—unnecessary to life and in many ways objectionable—consequently removed with impunity. In no other region of the body (and this only in the female) are organs so treated and abused. Pelvic surgery should be conservative always.

After the war there will be very little time for pelvic surgery, in fact little will be called for, because women will rise to

the emergency presented them, and "do their bit" uncomplainingly, as they always do in time of stress.

Clinical Eponymic Signs.

(Continued from Page 139)

BROADBENT'S SIGN—A visible retraction, synchronous with the cardiac systole, of the left side and back in the region of the eleventh and twelfth ribs, in adherent pericardium.

BRODIE'S SIGN—1. A black spot on the glans penis; a sign of urinary extravasation into the spongiosum. 2. Pain induced by folding the skin near a joint affected with neuralgia.

BROWN'S PHENOMENON — Brownian molecular movement. The spontaneous oscillating movements of inorganic particles or micro-organisms in a liquid medium. Same as Pedesis.

BROWNE'S (CRICHTON) SIGN—Tremor of the labial commissures and outer angles of the eyes in the early stage of paralytic dementia.

BROWN'S DIPPING CRACKLE SIGN—A fine crackling sound heard on placing the stethoscope over the right iliac fossa and dipping suddenly with it; heard in intestinal perforation in typhoid fever.

BROWN'S GRAVITATION SIGN—The area of tenderness in the lower abdomen is marked out. The patient is then turned on the unaffected side. If, in from fifteen to thirty minutes, the tenderness has moved one or two inches, or if the tenderness and rigidity should become marked, immediate operation is indicated.

BRUDZINSKI'S SIGN — 1. In meningitis, when the neck of the patient is bent, flexure movements of the ankle, knee and hip are produced. 2. In meningitis, when passive flexion of the lower limb on one side is made, a similar movement will be seen in the opposite limb; called also contralateral reflex.

BRYSON'S SIGN — Diminished power of expansion of the thorax during inspiration; occasionally observed in exophthalmic goiter and neurasthenia.

BURTON'S SIGN—A blue line at the junction of the teeth with the gums in chronic lead-poisoning.

CARDARELLI'S SYMPTOM — See Oliver's symptom.

CASTELLINO'S SIGN—See Oliver's symptom.

CHARCOT'S SIGN — In peripheral facial paralysis the eyebrow is raised, in facial contracture it is lowered.

CHARCOT-MARIE'S SYMPTOM — See Marie's symptom.

CHARCOT-VIGOUROUX'S SIGN—See Vigouroux's sign.

CHASE'S SIGN—Pain in the cecal region, felt when the examiner's hand is passed quickly and deeply along the transverse colon from left to right, the descending colon being closed by pressing deeply with the other hand.

CHAUSSIER'S SIGN—Pain in the epigastrium preceding eclampsia.

CHEYNE'S SYMPTOM — CHEYNE-STOKE'S RESPIRATION — A type characterized by rhythmic variations in intensity, occurring in cycles. It is seen especially in coma from affection of the nervous centers. Each cycle consists of a gradual decrease in the intensity of the respiratory movements, followed by total cessation for a space of from five to forty seconds; this in turn is followed by gradual increase of respiratory movements until they reach a maximum and become dyspneic in character.

CHVOSTEK'S SYMPTOM—Increase of the mechanical irritability of the motor nerves, especially the facial, in tetany. See also Weiss' Sign.

CLARK'S SIGN—A tympanitic sound over the hepatic region in tympanites due to perforative peritoneal inflammation.

CLAYBROOK'S SIGN—A sign of rupture of the abdominal viscera, consisting in the transmission of the sounds of the heartbeat and of respiration so that they can be heard over the abdomen, the transmission of the sounds being due to the presence of blood, exudate, or fluid.

CLOQUET'S NEEDLE SIGN—A clean needle is plunged into the biceps muscle; if life be not extinct, it soon oxidizes.

CLUMAN'S SIGN—Creasing of the skin just above the patella, indicative of fracture of the femur with overriding of fragments.

COMBY'S SIGN—Whitish patches on the buccal mucosa and the gums; an early sign of measles.

COOPERNAIL'S SIGN—Ecchymosis on the perineum and scrotum or labia; a sign of fracture of the pelvis.

CORRIGAN'S SIGN—An expansile pulsation felt in cases of aneurysm of the abdominal aorta.

COURVOISIER'S SIGN—A much distended gall-bladder from obstruction of the common duct indicates tumor rather than calculus.

CRICHTON-BROWN'S SIGN—See Brown's Sign.

DALRYMPLE'S SIGN—See Stellwag's Sign.

DAMOISSEAU'S SIGN—An S-shaped line on the chest, showing the upper border of pleuritic effusions.

DANCE'S SIGN—A depression about the right flank or iliac fossa, regarded by Dance as indicating invagination of the cecum.

DAVIDSOHN'S SIGN—The illumination of the pupil obtained on placing an electric light in the mouth will be less marked on the side on which there is a tumor or empyema of the antrum of Highmore.

DAVIS'S SIGN—An empty state and a yellowish or pale tint of the pulseless arteries; a sign of death.

DAWBARN'S SIGN—In acute subacromial bursitis, when the arm hangs by the side palpation over the bursa causes pain, but when the arm is abducted this pain disappears.

DE LA CAMP'S SIGN—Relative dullness over and to both sides of the fifth and sixth vertebræ in tuberculosis of the bronchial lymph-nodes.

DEMARQUAY'S SYMPTOM—Immobility or lowering of the larynx during deglutition and phonation; it is characteristic of tracheal syphilis.

DE MUSSEY POINT OR SYMPTOM — See Mussey.

DESAULT'S SIGN—A sign of intracapsular fracture of the femur consisting of alteration of the arc described by rotation of the great trochanter, which normally describes the segment of a circle, but in this fracture rotates only as the apex of the femur as it rotates about its own axis.

D'ESPINE'S SIGN—1. In the normal person on auscultation over the spinous processes, pectoriloquy ceases at the bifurcation of the trachea, and in infants opposite the seventh cervical vertebra. If pectoriloquy is heard lower than this it indicates enlargement of the bronchial glands. 2. In pulmonary tuberculosis the bronchophony over the spinous processes is heard at a lower level than in health.

DEWEE'S SIGN—Expectoration of tough whitish mucus by a pregnant woman.

DRUMMOND'S SIGN — The "oral whiff" heard when the mouth is closed and disappearing on compression of the nostrils. It is heard in cases of aneurysm of the thoracic aorta.

DUCHENNE'S SIGN — Sinking-in of the epigastrium during inspiration in cases of marked hydropericardium or impaired movement of the diaphragm from pressure or paralysis.

DUCKWORTH'S SIGN — Seemingly complete stoppage of respiration several hours before stoppage of the heart-beat; seen in conditions of intracranial pressure.

DUGA'S SIGN—Inability to place the hand on the shoulder of the other side while the elbow rests on the chest; seen in shoulder dislocation.

DUNCAN-BIRD'S SIGN—See Bird's Sign.

DIXON-MANN'S SIGN—See Mann's Sign.

DUPUYTREN'S EGGSHELL SYMPTOM—The sensation of a delicate crepitant shell (eggshell crackling) imparted on slight pressure in certain cases of sarcoma of long bones.

DUROZIEZ'S SIGN—A double murmur in the femoral artery due to aortic regurgitation.

ELLIOTT'S SIGN—Induration of the edge of a syphilitic skin-lesion.

ELLIS' SIGN — During resorption of a pleuritic exudate, the upper border of dull-

ness forms a curve, convex toward the head, the highest point of which lies laterally.

ERB'S SYMPTOM—1. Increase of the electric irritability of the motor nerves in tetany. 2. Dullness on percussion over the manubrium in acromegaly.

ERBEN'S PHENOMENON — A temporary slowing of the pulse on bending forward or attempting to sit down. It has been observed in neurasthenia.

ERB - GOLDFLAM SYMPTOM — Complex. Idiopathic muscular atrophy.

ERB-WESTPHAL'S SYMPTOM—See Westphal's Sign.

ERICHSEN'S SIGN—To differentiate coxalgia from sacroiliac diseases, compression of the two iliac bones causes pain in the latter but not in the former affection.

EWART'S SIGN—In marked pericardial effusion the left clavicle is so raised that the upper border of the first rib can be felt with the finger as far as the sternum.

FAGET'S SIGN—A fall in the pulse rate while the fever remains high or rises; seen in yellow fever.

FAGERSZTAJN'S CROSSED SCIATIC SIGN—In sciatica when the leg is flexed, the thigh can also be flexed, but not if the leg be held straight; flexing sound thigh with leg straight causes pain on affected side.

FEDERICI'S SIGN — On auscultating the abdomen the heart sounds can be heard in cases of intestinal perforation with gas in the peritoneal cavity.

FILIPOVITCH'S SIGN—"Palmoplantar phenomenon." A yellowish coloration of the prominent portions of the palmar and plantar surfaces seen in typhoid fever.

FISCHER'S SIGN—On auscultation over the manubrium with the patient's head bent backward there is sometimes heard, in tuberculosis of the bronchial glands, a murmur due to the pressure of the glands on the anonymous veins.

FISCHER'S SIGN—A presystolic murmur in certain cases of adherent pericardium.

FISKE-BRYSON'S SYMPTOM—See Bryson's Sign.

FLINDT-KOPLICK'S SIGN — See Koplick's Sign.

FLINT'S SIGN—A loud presystolic murmur at the apex in aortic regurgitation.

FLORA'S SIGN—A sound of neurasthenia consisting in defective tetanic response to prolonged faradic stimulation of the muscles alleged to be affected.

FORCHHEIMER'S SIGN — The presence of a reddish eruption on the soft palate in measles.

FOURNIER'S SIGN—The sharp delimitation characteristic of a syphilitic skin lesion.

FRANCKE'S SIGN—Deep tenderness over the apex of the lung behind.

FRANKEL'S SIGN—Diminished tonicity of the hip-joint muscles in tabes dorsalis.

FREDERICI'S SIGN — Perception of the heart-sounds over the whole abdomen in cases of perforative peritonitis with escape of gas into the peritoneal cavity.

FREIDMANN'S VASOMOTOR SYMPTOM - COMPLEX—A train of symptoms following injury to the head, consisting of headache, vertigo, nausea, and intolerance of mental and physical exertions and of galvanic excitation. It is occasionally associated with ophthalmoplegia and mydriasis. These phenomena may subside and recur with greater intensity, with fever, unconsciousness, and paralysis of the cranial nerves, ending in fatal coma. They are probably due to an encephalitis of slow development with acute exacerbations.

FREIDREICH'S SIGN—Diastolic collapse of the jugular veins in adherent pericardium.

FRIMADEAU'S SIGN — If the dilatation above an esophageal stricture is conical, the stricture is fibrous; if cup-shaped the stricture is malignant.

FUERBRINGER'S SIGN—A subphrenic abscess may be distinguished from a collection of pus above the diaphragm by the transmission, in case of the former, of the respiratory movements to a needle inserted in the abscess.

GANGOLPHE'S SIGN — In intestinal obstruction a serosanguineous effusion in the abdomen soon after strangulation has taken place.

GAREL'S SIGN—GAREL-BURGER'S SIGN—Luminous perception by the eye of the

sound side only, when an electric light is placed in the buccal cavity. It is observed in empyema of the antrum of Highmore.

GERHARDT'S SIGN—(1) A systolic bruit heard between the mastoid process and the spinal column in cases of aneurysm of the vertebral artery. (2) Incomplete filling of the external jugular vein on the affected side, occasionally seen in the thrombosis of the transverse sinus. (3) A band of dullness on percussion superimposed on the normal precordial dullness, about 3 cm. in width and extending toward the left clavicle. It is observed in cases of the persistence of the ductus arteriosus. (4) The absence of the movement of the larynx in dyspnea due to aneurysm of the aorta. In dyspnea from other causes the excursions of the larynx are extensive.

GERSUNY'S SYMPTOM—A peculiar sensation of adhesion of the mucosa of the bowel to the fecal mass while pressure is being made with the tips of the fingers in cases of koprostasis.

GIFFORD'S SIGN—Inability to evert the upper lid, seen in exophthalmic goiter.

GLASGOW'S SIGN—A systolic sound in the brachial artery, heard in latent aneurysm of the aorta.

GOGGIA'S SIGN—In health, the fibrillary contraction produced by striking and then pinching the brachial biceps extends throughout the whole muscle; in debilitating tissue, such as typhoid fever, the contraction is local.

GOLDEN'S SIGN—Paleness of the cervix uteri, regarded as a sign of tubal pregnancy.

GOLONBOFF'S SIGN OF CHLOROSIS — An acute pain located directly over the spleen, and pain on percussion over the ends of the long bones, especially the tibias.

GORDON'S SIGN—CARDIAC SIGN—A sign of cancer consisting of marked diminution in the area of cardiac dullness when the patient is in the recumbent position.

GOODELL'S SIGN—"When the cervix is hard as one's nose, pregnancy does not exist; when it is as soft as one's lips, pregnancy is probable."

GOULD'S BOWED-HEAD SIGN—In retinitis pigmentosa or other disease destroying the peripheral portion of the retina, the patient often bows the head low to see the pavement, in order to bring the image upon the functional portion of the retina.

GOUSSET'S SYMPTOM OF PHRENIC NEURALGIA—A painful point always present and well defined to the right of the fourth or fifth chondosternal articulation. It must not be confounded with the retrosternal pain of chronic aortitis.

GOWER'S SYMPTOM — Intermittent and abrupt oscillations of the iris under the influence of light, anterior probably to the total loss of the reflex; it is occasionally seen in tabes dorsalis.

GRAEFE'S SIGN—Failure of the eyeball to move downward with the upper lid in looking downward; seen in exophthalmic goiter.

GRANCHER'S SIGN—A raised pitch of inspiratory murmur, an indication of pulmonary consolidation.

GRASSET'S SIGN — GRASSET - GRAUSSEL PHENOMENON — Inability of a patient to raise both legs at the same time, though he can do either separately; seen in incomplete organic hemiplegia.

GRAVE'S SIGN—Increase of the systolic impulse often noted in the beginning of pericarditis.

GREENE'S SIGN—Outward displacement of the free cardiac border by the expiratory movement in pleuritic effusion.

GREISINGER'S SIGN—(1) An edematous swelling behind the mastoid process in thrombosis of the transverse sinus. (2) In thrombosis of the basilar artery, compression of the carotids produces symptoms of cerebral anemia (pallor, syncope, convulsions). This is a sign of doubtful value, since it may be caused by disturbance of the cerebral circulation resulting from cardiac and vascular lesions (especially arteriosclerosis).

GRISOLLE'S SIGN—The early eruption of small pox is distinguished from that of measles by the fact that the papules remain distinct to the touch even when the skin is tightly stretched.

(To Be Continued)

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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Dr. Huffman for Lieutenant Governor.

You have, no doubt, received the announcement of Dr. Huffman's candidacy for Lieutenant Governor. This announcement is, like the man, a very modest one. He admits that he has served in the State Senate for fifteen years, but he says no word of the very many things he has done for the medical profession of the state during that period of service.

There has never been a time during that fifteen years of service when he was on the wrong side of any question affecting our profession. He has been our main dependence in all legislative matters and we have yet to hear the first complaint or criticism of his conduct in the management of our interests.

It is certain that every member of the Society will vote for him, but that is not enough. In order that he shall be elected it is necessary that he be nominated at the primaries, and it is up to you, and all of us, not only to vote for him, but to get all the other people we can to vote for him. Get out and bring them in to the primaries—there are other candidates for the place.

State Association of Nurses to Maintain Present Standard.

The State Association of Nurses resolved to maintain the present standard of qualifications for registration. It was also resolved that the legislature be appealed to and that a three-year training course be made compulsory.

Time spent in preparation is a poor standard of qualification and, unless to the time requirement there be added a definite amount of specified work, it should never be established as a basis for estimating qualifications. Training schools for nurses should first establish a standard curriculum, and then may be justified the fixing of a time requirement.

We predict that whenever such a standard curriculum has been established, a much shorter course of training will be found to be fully as efficient as the present one of three years. It must be remembered that the three-year training course for nurses is full thirty-six months —the same number of months required for the completion of a medical course.

The general opinion seems to be that the course of training can be considerably shortened and at the same time be very much improved. It is doubtful if in any of the training schools the pupils get very much benefit from the didactic work which they are supposed to be given. There are very good reasons for that. The work is usually very indifferently given—one or two hours a day during the three years—by instructors not particularly interested in the nurses' training. The courses of instruction are not carefully adapted to the needs of the nurse—much of it is unnecessary, and much that should be given is neglected. The nurses have very little time for study, usually being compelled to use their recreation periods for study, or part of the time they should sleep.

With the present requirements for admission to the training schools, many of them are not sufficiently educated to grasp the subjects as they are presented.

Instruction in anatomy, physiology, materia medica, chemistry, bacteriology, principles of medicine, etc., should be given in the colleges where the proper equipment and instructors are to be had. There is no doubt but a much more thorough course in these subjects could be given in six months, possibly three months, than can possibly be given with the present plan. Students should not be admitted to the hospital until they have had this course.

Girls who have had at least a high school education and have completed such a preliminary course of instruction would more easily grasp the details of the practical work. Six months of general hospital training under competent supervision should amply prepare them for another six months of training in the operating room and in the various kinds of specialized nursing. Eighteen months of intensive training should develop as good nurses as are now produced in three-year training schools. It has even been suggested that the course of training could be efficiently completed in twelve months or even less.

Although the time would be very much shortened, it does not seem that the standard of qualifications would be reduced, if a carefully prepared curriculum be carried out.

It is hardly likely that such a reconstruction of the training courses could be accomplished by legislation, for legislation never leads but always follows any movement for the betterment of conditions. It can only be accomplished by the training schools themselves with the co-operation and assistance of the Association of Nurses. It seems that this is a splendid opportunity for the nurses in Kansas to take the lead in a very important advance movement. The first step required will be the organization of all the training schools into an association for the standardization and control of the training of nurses in Kansas. The next step will be the adoption of a standard course of instruction to be followed by all the training schools. The next step will be the classification of all the training schools in the state, according to their capacity and facilities for instruction.

One of the very necessary considerations is the small hospital. Its interests must not be neglected for it is too valuable an asset to the community, but upon the plan of instruction suggested the small hospital can fill a very important place and at the same time a corps of nurses always be available for its needs. These hospitals will give very satisfactory general hospital training, while the larger institutions can be utilized for the specialized training.

Such a plan would need to be very carefully developed and the courses arranged to terminate at such times that the hospital terms would overlap and thus permit the hospitals to always have a supply of experienced nurses in service. Kansas has a sufficient number of hospitals to give the required training to a much larger number of students than are now taking the courses, and it also has a sufficient number of excellent colleges in which the preliminary course of instruction could be given.

Nurses who have spent three years in training will perhaps not readily appreciate the possibilities in such a shortened period of intensive training, but a careful consideration of the details and a comparison of the proposed plan with the present system should readily convince them of the advantages of the former.

———R———

Make a Note of This.

The following letter shows the way for someone who wishes to join the medical corps and is tied up with a practice. Maybe there are others who will volunteer for such service:

"Moran, Kan., July 8, 1918.

"Dear Doctor: I am over age—cannot go to war, but am well and strong, able to go day or night, as yet, and if there is any place where a younger man has gone

to the front and a physician is needed, I would supply the place until the close of the war, and surrender it on the return of the physician. Thought I might help a little in this way. Yours truly,

"DR. S. K. WILLIAMS."

Kansas and Its Medical School.

Kansas City Star, May 7, 1918:

In William Allen White's latest book, "The Martial Adventures of Henry and Me," the story is told that the Germans even resort to treachery of the worst kind in order to kill doctors belonging to the medical staff of the Allies, figuring that the death of one doctor is equal to that of four soldiers, because the doctors are able to "patch up" wounded soldiers and send them back into the firing line without the loss of a great deal of time, not to mention the number of lives they are able to save.

Here, then, is a service which the state governments may render the country by developing to the greatest possible degree their state medical schools.

Take Kansas, for instance, which has almost criminally neglected its state medical school because of the cheapness of its state legislators who have wanted to keep down the taxes by limiting appropriations. Even recently it has been advocated that Kansas should close its medical school in order to save money for the liberal arts department of its university. It is now apparent to Kansas that it has missed a great opportunity to be ready to give the United States the support it needs in one vital particular, because of its failure to develop, instead of cripple, its state medical school.

The short-sighted policy of the Cheap John statesman always ends in humiliation to a state. Kansas is now paying the price in the matter of its medical school.

The War Department several months ago sent an appeal to every state to keep its medical schools going.

Kansas should prepare itself for meeting its share of the responsibility by bending every effort to build up its medical school, and every man who opposes such a plan should be discharged from the state service. This is no time for the Cheap John in public affairs.

Procaine and Novocaine Identical.

To the Editor: It appears that in certain quarters the attitude is taken that the local anesthetic sold as Procaine is not identical with that marketed as Novocaine. The Subcommittee on Synthetic Drugs of the National Research Council believes it important that this misunderstanding should be corrected and hence offers the following explanation:

The monohydrochloride of para-aminobenzoyldiethyl-amino-ethanol, which was formerly made in Germany by the Farbwerke, vorm. Meister, Lucius and Bruening, Hoechst A.M., and sold under the trade-marked name Novocaine, is now manufactured in the United States. Under the provisions of the Trading with the Enemy Act, the Federal Trade Commission has taken over the patent that gave monopoly for the manufacture and sale of the local anesthetic to the German corporation, and has issued licenses to American concerns for the manufacture of the product. This license makes it a condition that the product first introduced under the proprietary name "Novocaine" shall be called Procaine, and that it shall in every way be the same as the article formerly obtained from Germany. To insure this identity with the German Novocaine, the Federal Trade Commission has submitted the product of each firm licensed to the A. M. A. Chemical Laboratory to establish its chemical identity and purity, and to the Cornell pharmacologist, Dr. R. A. Hatcher, to determine that it was not unduly toxic.

So far, the following firms have been licensed to manufacture and sell Procaine: The Abbott Laboratories, Ravenswood, Chicago; Farbewerke-Hoechst Company, New York, N. Y.; Rector Chemical Co., Inc., New York, N. Y.; Calco Chemical Co., Bound Brook, N. J. Of these, the first three firms are offering their prod-

ucts for sale at this time, and have secured their admission to New and Nonofficial Remedies as brands of Procaine which comply with the New and Nonofficial Remedies standards.

While all firms are required to sell their product under the official name "Procaine," the Farbwerke-Hoechst Company is permitted to use the trade designation "Novocaine" in addition, since it holds the right to this designation by virtue of trade-mark registration.

In conclusion: Procaine is identical with the substance first introduced as Novocaine. In the interest of rational nomenclature, the first term should be used in prescriptions and scientific contributions. If it is deemed necessary to designate the product of a particular firm, this may be done by writing Procaine-Abbott, Procaine-Rector, or Procaine-Farbewerke (or Procaine [Novocaine brand]). Yours truly,

JULIUS STIEGLITZ, Chairman
Subcommittee on Synthetic Drugs, National Research Council.

Excerpts

BY THE PRODIGAL.

Does the practice of medicine pay? First, in a financial sense. If money is not the chief object in the practice of medicine, it is at least the first object to the man who has not inherited the means of support, since our physical wants are instant and continuous, and money is the means of gratifying them.

Can the physician in the pursuit of his practice acquire a certain competency? We are met at the outset by the difficulty of determining what a competency is. No definite amount can be named. So steadily do our real or fancied wants grow with the growth of fortune, that a competency has been wittily defined as being something a year more than we possess. A competency must mean an income sufficient for the maintenance of himself and family, for furnishing him with whatever equipments are necessary for the successful prosecution of his work, and which will leave at the end of each year something to invest for the future.

The time of life when a man is too young to practice medicine so nearly meets the time when he is too old to practice, that with the high noon of his work it is imperative for his income to be something more than sufficient for the passing day, that his mind be not burdened with anxieties for the future. It must be remembered that it is not so much the amount of his income as his method of expenditure that is the keynote of his financial standing.

Though money is first, it is not the chief object in the choice of medicine as a profession. "But who will deny that wit seems more witty, pathos more pathetic, eloquence more eloquent, and learning more profound when backed by ten thousand a year"? Also who will deny that wit and pathos and eloquence and learning do of themselves give distinction to their possessor independent of a bank account? Was Galen rich? No one thinks of inquiring. What we know of him is that he thought to so much better purpose than others that his views reigned almost supreme through the medical world for nearly thirteen centuries. Intellectual preeminence is always promptly recognized by the world, while the pecuniary circumstances of men eminent in thought are either entirely overlooked, or are considered only as aids or hindrances to them in their work accordingly as they are favorable or otherwise.

Of the professions, medicine offers perhaps the widest, freest field for him who would serve his generation and distinguish himself by new discoveries and inventions.

The highest ground, however, from which to consider human success, is not what a man makes of or by his work, but what his work makes of him.

Such a man will not fail to win patients and material success, but to the discerning mind the true summary of his success will be not of stocks, mortgages and real estate. Rather it will be said of him, as was said of Bias, the wise Greek, "Himself

is the treasure that a whole life has gathered."

(These excerpts are some of the high points in a paper read before the Republican Valley Medical Society at Concordia, April 3, 1890, by Dr. J. H. Brierly of Glasco.)

SCIATICA.

Sciatica, as a disease or entity, has been relegated to the diagnostic scrap heap, together with dropsy, intercostal neuralgia, biliousness and bellyache. They are symptoms only.

There are at least two known causes, with a shadowy background for a sympathetic cause, or reflex. The known causes are pressure and toxines. According to a late discussion in the Journal of the A. M. A., reflex causes run the whole gamut from fissure in ano to pyorrhea. The treatment consists in removing the pressure and antidoting the toxine. The surgical treatment was dwelt on mainly in the discussion, but practically nothing from a medical standpoint was mentioned. The discussion reminded one, in clearing up and making plain the cause of and the treatment of the pain in the sciatic nerve, of the "de novo" period, forty years ago, when few causes of disease were known and certain diseases were said to have originated "de novo." If the diagnosis did not satisfy the doctor, it served to blunt his professional conscience and satisfied his patient. The Prodigal has treated several cases of sciatic nerve pain and they yielded to quinine.

In eye pain or supra-orbital neuralgia, or sun pain, when the pain comes on in the morning and passes away in the evening, quinine is the treatment. It had a better effect when given in one-grain doses every hour until ten grains were taken. In some cases where a tolerance has been established, or owing to the virulence of the malarial poison, two grains were given every hour. From two to four days was the usual time of treatment. A mild cathartic at bed-time and two or three glasses of lemonade during the day hastened the cure. The cathartic flushed the sewer system and the citric acid favored the absorption of the quinine.

Conversion of Liberty Bonds.

Liberty bonds of the first and second issues and those obtained by converting bonds of the first issue into 4 per cent bonds can be converted into 4¼ per cent Liberty bonds during the six months' period beginning May 9, 1918. The new bonds will be dated May 9, 1918.

After November 9, 1918, no further rights of conversion will attach to the 4 per cent bonds, either the original bonds of the second loan or those obtained by conversion of bonds to the first loan. All of the 4¼ per cent bonds are nonconvertible.

Bonds for conversion may be surrendered at any Federal Reserve bank or at the Treasury Department. Registered bonds must be assigned to the Secretary of the Treasury for conversion, but such assignment need not be witnessed.

On conversion of registered bonds registered bonds only will be delivered, neither change of ownership nor change into coupon bonds being permitted.

Coupon bonds, however, may be converted into registered bonds upon request. Coupon bonds must have the May 15 or June 15, 1918, coupons detached and all subsequent coupons attached. Coupon bonds issued from conversion will have only four interest coupons attached, and later must be exchangned for new bonds with the full number of coupons attached.

The Hay Fever Season Is at Hand.

Physicians who have been using protective inoculations for hay fever with the Ragweed Pollen Protein for several years past, report such satisfactory results that those who have not put this method of treatment to the test should be encouraged to do so this year.

This treatment should be begun early to prevent the development of the trouble, although the severity of the disease is certainly very decidedly modified when treatment is begun late, and relief can be secured by the use of this treatment even after symptoms have begun.

While there are several very good prep-

arations of the Ragweed Pollen Protein on the market, it gives us pleasure to recommend particularly that produced by the Abbott Laboratories of Chicago. This is supplied as prophylactic treatment, consisting of four ampules, and also in 5 cc. blk. containers.

Are You a Kansan?

Since the Draft Law went into effect there have been many requests to the Kansas State Board of Health for certified copies of birth registration certificates. These could not be furnished because the vital statistics law providing for the registration of births and deaths did not become effective until 1911.

The State Board of Health has now arranged for the filing of birth certificates antedating the Kansas law. It will accept a certificate showing the name, sex, date, place, residence, full name of father and maiden name of mother and a certificate by the attending physician or midwife. If the signature of the attending physician cannot be secured, the Board will accept the certificate of reputable persons who may have definite knowledge of the birth. This certificate will be filed with the vital statistics department of the Board, and these records are maintained forever. There are many cases known in Kansas now where the failure to have definite birth records has prevented inheritances, and in a few cases has prevented the payment of claims of various kinds.

Following the close of the great war there will be hundreds of claims of various kinds appear, and in many of these a demand will be made for a certificate of birth. If this certificate were on file with the Kansas Board of Health it could be had in a few minutes' time. If it is not on file, the claimant would be required to go to considerable effort and expense to furnish the proper proofs.

This service and the records are available to any native Kansan, and it is hoped that all will avail themselves of the opportunity to fix a permanent record of their birth. Any physician will furnish a blank copy of birth certificate on request, or they may be obtained in any quantity from the city or township clerk. Properly filled out and returned to the State Board of Health it becomes a permanent record, accepted by the Government and the courts everywhere as the final proof of nativity.

TO PARENTS.

Is your child's birth registered?

If not, fill out this blank and mail it today to the State Board of Health, Topeka:

Full name of child.....

Sex.....Date of birth.....

Exact place of birth, city or township.....

..... County.....

Full name of father.....

Mail address .....

Maiden name of mother.....

Attending physician .....

A birth certificate is now required to obtain a passport to a foreign country, to obtain a soldier's pension, and to establish American citizenship.

A birth certificate may be required to establish identity; to enter school; to employment under child labor laws; to inherit property; to establish liability for military service and exemption therefrom; to vote; to hold title, to buy or sell real estate; to marry.

Later a birth certificate will probably be required to obtain a soldier's allowance for dependents, which is at present $15 for the wife, $10 for the first child, $7.50 for the second, and $5 for each of the succeeding children.

If you are a Kansas, file a record of your birth today.

The Hay-Fever Problem.

Notwithstanding the many "specifics" and "near-specifics" for hay-fever that have been brought forward in recent years, the disease, if not precisely enigmatical, continues to baffle and perplex. It is evident that no single therapeutic agent has arisen than can eliminate, or even modify, the symptoms in all cases, individual sufferers presenting problems

that are peculiar to themselves. The suprarenal substance, in the form of its isolated active principle, Adrenalin, is undoubtedly one of the most reliable alleviants. One feels justified in saying this in view of the long, efficient service it has rendered in the treatment of hay fever. Not infallible in a strict sense of the word, it affords grateful relief in a vast majority of cases. A powerful astringent, Adrenalin, topically applied, constricts the capillaries, arrests the nasal discharge, minimizes cough, headache and other reflex symptoms, and hastens the resumption of natural breathing. Adrenalin Chloride Solution and Adrenalin Inhalant are the preparations commonly used, being sprayed into the nose and pharynx. The former should be diluted with four to five times its volume of physiologic salt solution, the latter with three to four times its volume of olive oil.

Narcotic Addiction.

The military, industrial and public health features of narcotic addiction are discussed by C. E. Stokes, New York, in the Journal A. M. A., March 16, 1918. He claims that in some sections of the country 90 per cent of the narcotic victims are heroin users, and nearly all of these are in the period of adolescence, and many have reached military age. It would be illogical to expect 100 per cent efficiency at the outset of treatment of these persons, but with proper care and study many of them can be redeemed. Sooner or later the condition develops intovidualistic features. A chronic depression of nervous functions, and, further, this depression involves the ductless glands and other organs, causing disturbances of nutrition and emotional disorders, which are especially evident when the drug is suddenly stopped. From his experience with drug addicts, gained while in charge of an institution for their care and cure, it was clearly shown that they could be controlled by enlightened methods of discipline and administration, with proper environment. It is time, he says, that an educational drive be started, in which this problem can be taken up, stripped of its mystery and sensationalism, and the facts of the situation laid bare.

"The Laboratory that Knows How."

The Cutter Laboratory, of Berkeley, California, has for twenty years been serving the physicians of the country; but in order to better meet the requirements of the profession, they have re-organized and enlarged their Chicago office, and are better prepared than ever before to serve the interests of our readers. Accordingly this Journal has accepted their page announcement and is printing that announcement in this issue. If you find their service available for your practice, we bespeak for the Cutter Laboratory a share of your patronage.

WANTED—FOR SALE—ETC.

WANTED—South Central Kansas—competent physician for a $3,000 practice; collections good; population 500; one other physician; good farming community. "M," care Journal.

WANTED—Woman physician as assistant or partner. No objections to recent graduate. Address "Woman Gynecologist," care Journal.

FOR SALE—Established practice in good Kansas town for about half cost of office fixtures. $200, terms. Act quick. "H," care Journal.

FOR SALE—Central Kansas town, 650, main line Santa Fe. Beautiful eleven-room residence, bluegrass lawns, plenty of shade trees, fruit trees, cement walks, cement wash house, good garage, cement floor, good office furniture, at half price. One other doctor. Going to large town June 1. Good country around town. "Y," care Journal.

WANTED—To purchase a medical practice in Kansas or Missouri. Give full particulars in first letter. Address "S," care Journal.

WANTED—Practice in Kansas town, must be one that will furnish work from the start. Town under 1,000 population preferred. If you have real estate also, give description in first letter. "O," care Journal.

FOR SALE—Practice in good Kansas town, averages $400 to $500 per month. First class office on ground floor must be purchased in order to close the deal. Residence optional. This is gilt edge. "H," care Journal.

FOR SALE—Medical practice in Central Kansas, on main line of Santa Fe; ten teachers in school, 24-hour electric light service. Business for 1917—eleven months only—$4,723; cash, $4,319. Competition 20, 20, 18, 14, 13, and old practitioner in town. Population 400, territory 2,000. Office furniture and $100

drugs for $300. Rest optional, drugs, electric outfit, eye outfit, desk, typewriter, instruments and case, Ford car. Will join Medical Reserve when I put a successor in the field. Competition easy and business will increase as others leave the vicinity for the army service. Successor will hold all the present business and increase it. Possession any time. Address "S," care Journal.

R

Testicle Implantation.

G. F. Lydston, Chicago (Journal A. M. A., March 30, 1918), reports the later results of testicle implantation of two cases, which had been reported after the earlier operations. In the first man aged 30 was operated on in August, 1915, after physical feminism and mental impairment and inefficiency had begun to appear. A rapid change in gain in masculinity was obtained and the improvement continued to the present time. The second case was a boy aged 13, who was developing almost as a girl, after losing function of both organs from orchitis. After a six months' treatment with faradism there was slight improvement, but after two years there was no

Campbell

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AND
High Frequency
Apparatus

Campbell X-Ray Apparatus has been used by the United States government almos exclusively for the past tbree years, the most notable single installation being that of the seven camp hospitals along the Mexican border last year.

At the Panama-Pacific International Exposition in San Fracisco, 1915, Campbell X-Ray and High Frequency Apparatus received the Medal of Honor, the highest award given any manufacturer of X-Ray apparatus.

At the last International Red Cross Conference, the Campbell Electric Company was the only manufacturer of X-Ray apparatus in America to receive an award. Seven nations were represented in the jury making the award.

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Dr. W. H. Manser, Burden, died April 23, 1918. Dr. Manser was born in 1859, graduated in medicine at the Kansas City Medical College in 1889. He was a member of the Kansas Medical Society and of the American Medical Association.

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(1941)

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, AUGUST, 1918 No. 8

The Responsibility of the Profession Toward the Disabled Soldier.

G. CANBY ROBINSON, St. Louis, Mo.

Address before the Kansas Medical Society at Kansas City May 2.

The millions of wounded and crippled soldiers in the belligerent countries of Europe present to the world the greatest problem it has ever had to face in the care of human beings.

Man-power must be conserved not only to win the decision of the battlefield, but also to triumph in the great economic struggle to follow the war. In this process of conservation, the medical forces must do their utmost to restore physical efficiency, while vocational training and industrial adjustment must continue with the work until each man is brought as near economic independence as possible.

Our country has been notoriously lacking in conservation of its resources, both natural and human. But now as we enter this war, the lesson which should have been long ago learned, faces us, to be learned in a hurry. If we fail now to learn it and to take it to heart, long may be the time of our regret. The fact that necessity is about to teach us to save our resources and our men is a beneficial by-product of the war, and in these days when our casualty lists have begun to come home to us, it is well to dwell upon some of the benefits our country is to gain by war.

It is estimated that of every million men sent over-seas into service, one hundred thousand will come back permanently disabled for further military service. Of these, twenty thousand will need to be taught a new trade or new methods of their old trade or will need to be trained in a new type of vocation before they can become self-supporting. We must awaken to these facts, especially as the solution of these new problems depends upon a wide co-operation in all parts of the country from which our men have gone forth. The doctors who remain at home, as well as those who go, will have opportunities of sharing in the solution of these problems, and all should have a knowledge of the fundamental principles involved in refitting the disabled soldier for civilian life. Service may be rendered directly to the soldier on his return both by medical attention and guidance or indirectly by helping to adjust public opinion so that the disabled soldier is most wisely helped.

I propose to review briefly therefore the main steps in the process of refitting the crippled soldier for civilian life and I shall try to point out wherein lies the opportunities and obligations of the profession in this matter.

The question that is being asked and answered throughout the world is, what is the best method of bringing the wounded and disabled soldier to the highest possible state of efficiency and happiness? Naturally the answers from different parts of the world differ, because the solution of this problem must take into account many factors which are by no means constant. The temperament of the people, the social, economic and political conditions, the resources and opportunities, differ in different parts of the world. There are, however, some principles of a fundamental

nature which seem to be generally agreed upon.

First and foremost, the disabled soldier must be provided with the best medical and surgical care that his nation can provide. From the moment the wounded soldier is reached by the stretcher-bearer until his release from military service, every possible need must be provided. The regimental surgeon in the dressing station, the doctor and nurse in the casualty clearing station, the medical force at the base hospital must do their utmost to restore once more the man to military fitness.

If this cannot be done the disabled soldier must be sent back to the part of the world from whence he came to be reconstructed and refitted for civilian life. From 30 to 40 per cent of all military forces will at some time pass through a hospital, while 10 per cent will be found unfit for further military service. It is with this latter group, one hundred thousand for every million men in active service, with which we are concerned.

The second principle which has been generally accepted is that the most perfect mechanical aids must be provided for the crippled. The mechanical devices employed by each man must be selected not only after a careful consideration of his injury, but also after the determination of the kind of work he is to do. Great advances have been made in the construction of artificial hands, arms, and legs, notably by Amar of Paris. He has introduced accurate tests to determine the relative usefulness of various appliances, and the amount of fatigue engendered by their use. Many ingenious devices have been invented to enable the crippled to carry on various mechanical processes, and these are not limited to attachments to the limbs, but include braces, rings, belts, clamps, hooks and supports attached to various portions of the anatomy. The men with amputated hands are supplied with working hands and so-called "Sunday hands." Prizes and competitions have stimulated the production of the mechanical aids which are useful in refitting the crippled soldier for industry.

The third principle that has been generally recognized is that occupation must be provided for the disabled soldier who is to return to civil life as soon as he is able to do anything. It is during the period of convalescence that the battle of the spirit and the will is fought, and it is during this time that the disabled soldier decides what he will endeavor to make of his future. Useful and congenial occupation under the tactful guidance of a trained teacher may be of the greatest importance in directing the confused mind of the invalid into an attitude of hope and determination.

Occupation during the period of convalescence has also proved of great therapeutic value. It has been repeatedly pointed out that the natural exercise of a stiffened joint or an injured limb secured during the performance of some useful occupation is much more beneficial than the artificial exercise obtained by gymnasium or Zander apparatus of the so-called mechano-therapy. Sir Robert Jones, military inspector for orthopedics of the British Medical Corps, emphasizes the importance of occupation for the effect that it has on the mental, moral and physical welfare of the disabled soldier. To illustrate the advantage of exercise obtained by useful occupations over that obtained by mechanical devices, he takes a man with stiffened fingers. These may be exercised by spring dumb-bells, which he endeavors to squeeze together during prescribed periods. But give that man a duster and "his mind is set on the dust he has to remove, not on the fact that his maimed hand is repeatedly taking hold of and letting go the duster."

Work during the period of convalescence is considered such an important aid to medical treatment in reclaiming the wounded to industrial life, that a new term, "occupational therapy," has come into general use. The Federal Board for Vocational Education in Washington has issued a bulletin of seven-five pages on the train-

ing of teachers for occupational therapy for the rehabilitation of disabled soldiers and sailors. The bulletin points out the requirements such teachers must fulfill and the qualifications they must have. The "occupational therapeutist," as these teachers are called, must have a background of both medicine and industry. He must be a master of the work he is teaching. "He must know how to restore self-confidence in the discouraged, how to awaken ambition in the disheartened, and how to develop perseverance in the restless. Quick results are necessary for the encouragement of some, painstaking accuracy for the progress of others. The therapeutic value of a process is gone for some patients the moment they master it, and recovery is measured by the systematic change from process to process, each demanding more initiative or concentration. Continued practice, long after the mastery of the process, gives to other patients just that assurance and self-reliance necessary for recovery. The occupational therapeutist must know the functions of muscles, how they may be exercised, how the brain may be stimulated or relaxed and how the co-ordination of body and mind may be produced." Personality is the first qualification of the teacher, and the peculiar problems involved in working with the handicapped necessitate force, resourcefulness, tact, sympathy and courage.

Experience has shown that frequently the best teachers are obtained from among the handicapped themselves. This has been particularly true in the reeducation of the blind, most successfully carried on at St. Dustan's in London under the guidance of Sir Arthur Pearson, who is himself blind. It is a great source of encouragement to the disabled to see before them what others in a similar plight have accomplished, and a bond of sympathy is quickly established.

The types of occupations that may be taught and carried out during the period of convalescence must cover a wide range. They may be divided into invalid occupations which are carried on in bed or in a chair, and occupational therapy which is carried out in class rooms and shops attached to the hospital. The choice of the work must depend upon the patient's previous education, inclination and physical condition. Primary education is of course of first importance, and no doubt some of our soldiers will have to be taught English. Basket making, typewriting, bookkeeping, mechanical drawing, net and hammock making and leather work can be taught to men in bed. Shoe making, tailoring, woodwork, toy making and motor building are among the many useful trades that have been used in shops for occupational therapy, that have been established in connection with some of the large hospitals abroad and in Canada. Gardening and chicken raising have been found useful, especially for men who prefer or require outdoor work.

During the period of convalescence occupation is necessarily secondary to medical treatment, and it can usually not go very far in teaching a new trade. The type of work during this period is determined by the medical needs as well as by the physical restrictions of the patients. Patients may be divided into those who will never recover sufficiently to compete in the industrial world with normal men, those who must have special vocational training after completion of the medical treatment in order to enter the industrial world, and those who can enter industry as soon as convalescence is complete. These three groups of patients must go along different routes as soon as they have reached the point where hospital care is no longer an advantage in their medical treatment. During the period of convalescence the course that each man should follow later must be determined and emphasized to him, and each must leave the hospital with a clear idea of what is necessary thereafter for the best development of his future. He must also clearly understand where the assistance that he needs is to be found and how it is to be utilized. It is presumably at this time that the soldier obtains his discharge from the army and

returns to his home.

The social worker should have a recognized place with well defined duties in the reconstruction hospital, and should work in close co-operation with both the doctor and vocational teacher. The problems that are peculiar to the readjustment of each individual patient should be sought for and carefully considered. It should be the duty of the social worker to find out if possible where each man would be likely to fail along the road toward self-support and independence. These disabled soldiers will need encouragement, sympathy, and friendliness, and their attitude toward life will need perhaps as much training as their injured bodies. They must be shown the way to better things than they have known before. Months of invalidism, the patriotic praise and gifts showered upon the wounded soldier, and weary months of warfare and not conducive to determination to win a place in the world. The fact that the crippled soldier is to receive a well earned pension too, is an obstacle to his determined efforts. These unavoidable forces must be met by experts trained in dealing with human adversity, and herein lies the field for the well trained social worker who is accustomed to see clearly what is needed, and who is not hampered by the sentimentality which is so apt to hinder the work of the amateur.

When the disabled soldier leaves the hospital he presumably leaves the military service of his country. He is then ready either to enter into his previous career or he is ready for vocational training to fit him for the sort of activity his physical disability will allow. He has had all that hospital care can do for his medical and surgical needs, he has received and learned to use the artificial appliances he requires, and he has had some training of the body and mind to aid him to live and compete as an independent individual. The fourth step in refitting the disabled soldier that has been established where large numbers of disabled soldiers have been cared for, is intensive vocational training which will make him capable of maintaining himself and his family on the scale of living to which he is accustomed. This training must be taken up voluntarily and he must see and take for himself the opportunities that are provided. These opportunities must be found at or near his home, and so vocational training for disabled soldiers must be widely distributed throughout the nation. It is in the establishment of this process of readjustment that wide co-operation is necessary. Public opinion must be educated, for many must take a hand in the work. Doctors, schools and teachers, employers, labor unions, individual industrial workers and the public at large must join forces in every community to train and place in industry the man who has suffered for his country.

Various methods have proved successful in providing the necessary training. In large cities trade schools have been established where the men may attend, either coming daily for their lessons or living in the school. Existing institutions have offered freely their facilities and have given special courses for the crippled. Universities, public schools and manual training schools have opened their doors and provided the special work required. At McGill University in Montreal the facilities of the engineering faculty have been placed at the disposal of the Invalided Soldiers' Commission. The electrical laboratory, the steam laboratory, and the draughting room, with the services of instructors, have been made available to returned soldiers in need of re-education.

Another plan which has been employed, but less successfully, is the introduction of the crippled into factories and workshops as apprentices under special supervision. Night courses have also been conducted in industrial plants. The problem of providing vocational training for men who return to small communities or agricultural districts is more difficult. Often these men will have to attend special courses offered by agricultural colleges and at times several communities will have to combine to provide the needed training. To meet these difficulties local committees or socie-

ties have been formed in the various countries at war. In England the local pension committees have this work in hand. Canada has been completely organized by provinces, over which the central office of the Military Hospitals Commission has control. In each province there is a vocational officer, under whose direction all local activities are carried out. The formation of a federal commission known as the Board for Vocational Rehabilitation has been proposed in this country to carry on this work. A bill for the formation of such a board has been introduced into Congress and an appropriation of ten million dollars has been asked for to carry on this work.

In directing his future course, the disabled soldier will have to be discouraged from accepting positions which are available during the duration of the war, but from which he will be displaced when the millions of men now in the armies of the world return to their usual occupations. He must be discouraged also from depending on such work as the manufacture and sale of war souvenirs which will have but a passing value. He must be encouraged to prepare himself to win a secure place for himself in the economic world which is not sustained by charity or sentiment. Both of these aids are sure to pass as the war becomes more and more a past event.

It is not enough to provide training facilities for the disabled soldier. He must be supported while he is being trained, and what is more his family must be kept from want. Such provisions have been generally adopted. The service pay and separation allowances are continued during the period of training and usually for a month after his training is completed or until he finds suitable employment. The man must also be paid for his work as soon as it comes to have a commercial value.

It has also been necessary in all countries to emphasize the point that increased industrial proficiency does not decrease the amount of the pension that has been allowed. The idea that the pension would be reduced by industrial training kept many soldiers at first from undertaking it. It has been emphatically declared to these men that the pension is granted for service rendered and for the disability sustained for the sake of their country, and it cannot be reduced by future developments.

The opportunities and benefits of industrial training for the crippled soldier has been given wide publicity by means of pamphlets, posters, cards, moving pictures and talks in hospitals in camps. The many enthusiastic letters which have been written by trained cripples have been circulated and have proved of much value. It is especially encouraging to read the oft repeated account of how, although physically disabled, many have improved their earning capacity by their training and now hold positions requiring greater skill and responsibility than before enlistment.

To summarize what has been said, the return of the disabled soldier to civilian life involves at least five distinct processes, each depending upon and interweaving with the others.

These are the best of medical care, the use of carefully selected and properly devised mechanical appliances, occupational therapy, vocational training and, finally, the careful placement and oversight in industry. Of this last phase very little has been said, and is a large subject which cannot here be more than mentioned.

Let us now consider briefly the responsibilities of the profession toward the disabled soldier. These may be divided into at least three groups: intelligent medical and surgical after-care, encouragement and psychological guidance, and constant efforts to shape public opinion in his behalf.

Intelligent medical and surgical after care of disabled soldiers means more than putting forth our best professional efforts. It means as well understanding something of the industrial conditions the men will be called upon to fill. It means also in the case of cripples the adjustment of artificial appliances to their work. The government proposes to carry out this work as far as possible, but doubtless in

many cases readjustments to industry will be necessary months after the soldiers have gone from under the control of the government, and in many instances men disabled in the war will soon come to depend once more on their own physicians. It is important that physicians should have some knowledge of the working conditions of their community, whether they are industrial, agricultural or mercantile. This knowledge should be used in advising and treating the disabled soldier who may be under his care. There is a wide application of this principle in the care of the civilian population as well.

The fact that encouragement and treatment of the mind of the disabled soldier is of great importance in his rehabilitation has been already considered. The work must be continued by the doctor at home, and it is principally for this reason that an understanding of the disabled soldier problem is so desirable. These men must not be allowed to fall back when once they have made a start, and their determination must be especially stimulated after they have returned to their old surroundings. Perhaps no one is in so favorable a position as the doctor to encourage and guide, persuade and force the disabled soldier to put forth an effort to do work which is essential for the welfare of the state and for his own ultimate happiness. The government will provide the ways and means, but the inner man must do the rest, and the influence of the true physician on the inner man is or ought to be forceful and uplifting.

Lastly, the members of the medical profession must exert constantly their influence to obtain for the disabled soldier the hearty, general co-operation and assistance that he needs.

This subject has been admirably expressed by the Red Cross Institute for Crippled and Disabled Men of New York, under the caption "A Square Deal for the Crippled Soldiers," as follows: "When the crippled soldier returns from the front, the government will provide for him, in addition to medical care, special training for self support. But whether this will really put him back on his feet depends on what the public does to help or hinder. In the past, the attitude of the public has been a greater handicap to the cripple than his physical disability. People have assumed him to be helpless. Too often they have persuaded him to become so.

For the disabled soldier there has been "hero-worship"; for the civilian cripple there has been a futile kind of sympathy. Both do the cripple more harm than good.

All the cripple needs is the kind of job he is fitted for, and perhaps a little training in preparation for it. There are hundreds of seriously crippled men now holding down jobs of importance. Other cripples can do likewise, if given the chance.

Idleness is the calamity too hard to be borne. Your service to the crippled man, therefore, is to find for him a good busy job, and encourage him to tackle it.

Demand of the cripple that he get back in the work of the world, and you will find him only too ready to do so.

For the cripple who is occupied is, in truth, no longer handicapped.

Can the crippled soldier count on you as a true and sensible friend?

Care and After Treatment of Surgical Cases.

J. A. FULTON, Kansas City.

Address before the Kansas Medical Society at Kansas City May 2.

The first part of this paper, or what I mean by "care," should begin at the time the patient enters the hospital, or even before that, if possible. The patients entering the hospital should always be shown the greatest courtesies, kindness and assurance that they will have the best care and attention possible. The first thing to do is to see that they are made comfortable and have a good rest, become acquainted with the attendants, nurses, etc. This should be done before they are examined by the surgeon. By so doing, it is a great aid in getting all fear and excitement out of their minds.

The preparation should be, first, to find

out the position in which the patient usually lies naturally or with comfort, or to protect himself from pain. The positions means much to him. To illustrate: A young person with acute appendicitis; you at once observe the position in which the patient is lying. The patient does this to protect himself from pain. It is well to keep them in the same position before they are operated upon, and especially so after the operation.

It is sometimes necessary to give them morphia. Diet should always be liquid; and in any of the acute cases of the abdominal cavity no cathartics should be used. All these acute cases must be considered from the attendant's standpoint as emergencies and treated so by him, the same as a surgeon. In non-acute cases, time should be taken always to give them a careful preparation. I do not mean from the surgical standpoint, but from the attendant's standpoint, as a preparation of the cases is your great anchor and prevention in the after treatment. Most of these cases that enter the hospital are tired, excited and worn out from travel and the loss of sleep; so, first, all such cases should have at least one good night's sleep before operated upon, and it would be much better if they had two. Frequently it is necessary to give morphia or some of the bromides to accomplish this.

Second, it is well to have a thorough elimination of the bowels. This should be given at least eighteen hours before the operation. Nothing, in my opinion, is equal to castor oil in adult cases, two ounces at a dose. After a thorough evacuation one-sixth of morphia is given. This is to stop peristaltic action of the bowels. Nothing should be taken per mouth after the dose of morphia is given before operation, except a small amount of water. This should all be accomplished the night before operation.

The morning of the operation, a second dose of morphia, grains one-sixth, and atropin $\frac{1}{150}$, one-half hour before the patient is taken to the operating room. This is given to quiet the patient, to stop peristalsis, to numb the vasomotor system, to prevent pain, to save a large amount of anesthesia, to quiet respiration, to stimulate the heart, and as a preventive in operative and post-operative shock.

Great care should be taken that the patient's body temperature be kept at normal. The operating table should be warm, the patient well covered with blankets, and as little of the body exposed as possible. Also, the position in which the patient is lying should be carefully considered. The head should be slightly elevated, turned to one side or the other, the anterior posterior curvature of the spine should be well padded, either with an air cushion, pillows or a folded blanket, to prevent the relaxation of the vertebral muscles. In so doing, in the greater per cent of cases you will have no so-called ether backache. I do not believe that ether, chloroform or nitrous oxid oxygen causes backache.

The next to be considered in the after treatment is the prevention of pain. It is just as important that your patient suffers no pain after surgical work as it is during the operation. No surgeon would think of operating upon a case without an anesthetic, for the pain that he would produce; so one should be very careful that his patient suffers no pain the first forty-eight hours after operation. Pain is best controlled by a thorough preparation of your cases, as mentioned above; no nausea from the anesthetic, no hard drainage tubes, that will produce peristalsis, no diet which increases peristalsis, no tight skin sutures which keep up constant pain; no tight abdominal bands which may cause pressure; no company, which may cause the patient to move or exert himself; no bright light shining in the patient's face; and, last but not least, the patient's position in bed. Let the patient be in a position in which he is most comfortable; and, as I have stated before in this paper, this may be found out before the patient is operated upon.

Our whole object should be, in the after treatment of surgical cases, the prevention of shock. The attendant should study ev-

ery possible means for prevention in post operative shock. He should have a regular routine, as near as possible, the same as a surgeon has in the prevention of infection. Quoting Dr. Crile on "Shock and the Causes of the Same," "I fear we pay too little attention to pain." As he states, 80 per cent of all shocks is caused from pain or vasomotor exhaustion and 10 per cent is caused from hemorrhage, and that the remaining 10 per cent is unknown, why should not the surgeon in his operative work be as careful not to cause undue pain as he would be in controlling hemorrhage? Why should he not also be as careful in controlling pain after the surgical work is done as he would be post-operative hemorrhage? If the surgeon had a wound that was continually oozing blood, he would immediately take steps to stop it; but how many pay attention to the pain, which is just as detrimental as hemorrhage to the patient?

If we recall a great number of cases, in what class of cases do we get shock? From my experience, it has been gall bladders, stomachs, hysterectomies, prostatectomies, and burns, and these have all suffered shock from pain. Very few cases have suffered shock from hemorrhage. I think the Crile theory carries this out well, in which he states that in a burn caused by the X-ray, where a great portion of the body was burned, there was no shock because there was no pain, but in a burn of a small area by steam or fire, they suffered great shock because of the pain. I think, also, his dog story is a good illustration, where he took two dogs, one of which he bled, taking half of the blood from the dog. The second dog he did not bleed, but fractured both legs and tortured the dog, causing the dog great pain. This dog suffered great shock, rapid pulse, dilated pupil, etc.

The main object of this paper is to impress upon the surgeons the necessity of a better technique to prevent pain, more careful handling of the abdominal viscera, less tugging of any parts of the abdomen, always sharp dissection, and the position in which the patient is placed during and after surgical work. Our object in all of this, as stated above, is to prevent pain; and in so doing prevent shock. This, I consider, is the best after treatment; but if we should have shock following the operation, get the patient comfortable in bed, and heat to the body. As all these cases have subnormal temperature, also low blood pressure, absolute quiet, and if shock is caused from pain, put the body at rest with morphine. Quoting Crile again, it is our only drug. What I mean by putting the body at rest is the organs of respiration, the heart, the peristalsis, etc. If the patient is awake and not nauseated, a glass of warm water and 15 grains of sodium bicarbonate every hour or so is an advantage. Proctoclysis of a 2 per cent solution of sodium bicarbonate, 60 drops per minute, has proven good. Stimulants of no kind with the exception of morphine are indicated, as it is a well known fact that strychnin will cause shock. The whole idea is to keep the patient at rest, not to stimulate an overworked heart.

In shock caused from hemorrhage, the treatment is practically the same, with the exception the fluids are best given intravenously. I prefer a 2 per cent solution of sodium bicarbonate. The amount given will depend entirely upon the blood pressure. As we well know, in case of shock or low blood pressure, the alkalinity is greatly diminished. By adding sodium bicarbonate we raise the alkalinity of the blood, increasing the blood pressure and temperature of the body. We should always be careful not to give too much fluids intravenously. This is especially true of normal saline.

The treatment of gas pains commences with the preparation of the patient, diet and position of patient. If we have gas pains and any laxative is necessary, I still believe castor oil is the best. The dose should be given in the morning, so as not to disturb the patient at night. And in about two hours afterwards, an enema, formula as follows: Milk 8 ounces, water 8 ounces, cane syrup 4 ounces. This

works very rapidly and much better than soap or ox gall enema.

I have prepared lantern slides illustrating the different positions in which patients should be placed following operations, which have been of great benefit to the patient and great satisfaction to myself. I think that in the near future we shall be able to prevent nausea and vomiting after anesthesia, gas pains and shock, by more careful technique in the preparation, and that we will have no larger per cent of the above mentioned items than the careful surgeon has infections. As one of the Mayos said, the man who operates his case should have nothing to do with the after treatment of the case, as surgeons are not usually good internists, and most of them consider their job done when the patient leaves the table.

Case Studies of One Hundred Inmates of the Kansas State Industrial Farm for Women.

SHERMAN L. AXFORD, M.D., Prison Physician.

In view of the recent activities on the part of the government against venereally infected women, and the recent establishment of the Kansas State Industrial Farm for Women, I thought possibly the case studies of a hundred would be of interest to the physicians of Kansas.

To give anything like a complete sociological case history of delinquents it is, of course, necessary to have a complete family history and to know much of the inmate's social and family environment. This we are unable to give because of lack of personal investigators. Under the heading of "Offences," Adultery, Vagrancy and Violation of Chapter 205, Session Law 1917, could well be classified under the one head "Lewdness."

In the intelligence examinations the Yerkes-Bridges Point Scale system was used. This is a hundred-point scale, 82 points figuring the mental age of fifteen years. The psychologists who use the Yerkes-Bridges system consider the mental age fifteen years as a normal mentality.

The detailed table gives such actual data as I was enabled to glean from the case-examination of those considered. Accepting the Yerkes-Bridges Scale as a true test, we find that 80 per cent are mentally normal, or better, and that the average for the hundred women under consideration is near three points (84.9 points) above normal. The high mentality is contrary to the generally accepted belief concerning women who come under the law's restriction for lewdness.

It is noticeable that the Indian women show the highest mentality under the Y.-B. test, their average being 90 points. The white women are nearly four points below, being 86.35, or 5½ points above normal. The black women are the lowest in the scale, yet they do not show a serious abnormal mental condition, being only one-half point below the normal test fixed by the Y.-B. standard.

If these hundred women can be used as a standard for women whom society and the law have condemned, the "low mentality" of the women offenders is not borne out by the facts as here shown. The deductions made here show that 76 per cent of the white female offenders are normal or above, that 20 per cent of the negro women are the same, and that every one of the Indian women are above the normal mentality.

The general history of the women under consideration is not very illuminating, yet there are a few points that are worthy of consideration. The youngest woman in the compilation is fifteen years old and the oldest is forty-seven years, the average being twenty-four and one-half years. Sixty-two per cent of the women are less than twenty-five years of age. All were of American nativity except one. Thirty-nine were natives of Kansas. The offenses for which these women were committed were 93 per cent for lewdness. Eighty-eight per cent of these women were suffering the law's penalty for the first time

and 12 per cent were recidivists. Eighty-one per cent of the women were raised by their own parents while 19 per cent were cared for by step-parents. Seventy-four per cent left their homes between the ages of fifteen and eighteen years; 2 per cent are absolutely illiterate; 71 per cent had schooling only through the lower grades; 7 per cent graduated from high school. Seventy per cent of the women had been married, and of these 22 per cent were divorced. It may be noted that 5 per cent of the divorced were where the marriage tie had been annulled because of the extreme youth of the wife, desertion and non-support account for 77 per cent of the divorces, while adultery is only alleged in 9 per cent. Thirty-five of the women had given birth to ninet-one children, and twenty-seven stated that they had had forty-eight miscarriages; but three of the children born were illegitimate. Seven of the 100 women were pregnant when admitted.

The mentality of the women does not seem to be abnormal nor do their habits, so far as the use of liquor, tobacco and drugs are concerned. Five per cent use liquor, 6 per cent use tobacco other than in the form of cigarets, 21 per cent plead guilty to the cigaret habit, 2 per cent use drugs, while 66 per cent use neither liquor, tobacco or drugs.

When these women came under my charge 80 per cent were infected with syphilis, 87 per cent had gonorrhea and 55 per cent were suffering from both diseases.

The details are given in the tables which follow:

GENERAL HISTORY.

AGE—	Per Cent
Between 15 and 20 years	23
Between 20 and 25 years	39
Between 25 and 30 years	20
Over 30 years	18
	Years
Average	24.62
Minimum	15
Maximum	47
COLOR—	Per Cent
White	69
Black	28
Indian	3
NATIONALITY—	
American	68
Afro-American	28
American-Indian	3
English	1
NATIVITY—	
Kansas	39
Other States	61
OFFENSE—	
Adultery	9
Vagrancy	42
Violation Chap. 205, Ses. Laws 1917	42
Grand Larceny	7
IMPRISONED—	
First time	88
Second time	9
Third time	3

PERSONAL HISTORY.

REARED BY—	Per Cent
Own parents	81
Step parents	19
AGE LEFT HOME—	
Under 10 years	4
Age 12 years	1
Age 13 years	7
Age 14 years	5
Age 15 years	6
Age 16 years	20
Age 17 years	10
Age 18 years	15
Age 19 years	8
Age 20 years	4
Over 20 years	20
EDUCATION—	
None	2
First, Second and Third Grade	7
Fourth, Fifth and Sixth Grade	27
Seventh and Eighth Grade	37
First year High School	10
Second year High School	8
Third year High School	2
Graduate, High School	7
SOCIAL CONDITION—	
Married	48
Divorced	22
Single	30
CAUSE FOR DIVORCE—	
Non-support	45
Desertion	32
Adultery	9
Annulled account age	5
Cruelty	9
HAVING GIVEN BIRTH TO CHILDREN—	
White	28
Black	7
Indian	0
HAVING HAD MISCARRIAGES—	
White	18
Black	6
Indian	1
HAVING GIVEN BIRTH TO CHILDREN ILLEGITIMATE—	Per Cent
White	3
Black	0
Indian	0
HAVING HAD MISCARRIAGES ILLEGITIMATE—	
White	3
Black	1
Indian	0
CHILDREN—	Number
Number of children given birth to by the 35 women	91
MISCARRIAGES—	
Number of miscarriages by the 27 women	48
HABITS—	Per Cent
Use liquor	5
Use tobacco (other than cigarets)	6
Use cigarets	21

Use drugs	2
Use neither	66
VENEREAL DISEASE—	
Has syphilis	80
Has gonorrhea	87
Has both syphilis and gonorrhea	55

INTELLIGENCE TEST OF INMATES.

	Per Cent
MENTAL AGE—	
9 years	3
10 years	1
11 years	8
12 years	5
13 years	3
15 years and over	80
MENTAL AGE BELOW 15 YEARS—	
White	8
Black	12
Indian	0
MENTAL AGE ABOVE 15 YEARS—	
White	61
Black	16
Indian	3
OF THE TWENTY INMATES MENTAL AGE BELOW 15 YEARS—	
White	40
Black	60
Indian	0
OF THE EIGHTY INMATES MENTAL AGE ABOVE 15 YEARS—	
White	76
Black	20
Indian	4
NUMBER INMATES TESTED 100—	
White	69
Black	28
Indian	3
AVERAGE YERKES-BRIDGES POINTS—	Points
White	86.35
Black	81.43
Indian	90
Average Yerkes-Bridges Points for the 100 women	84.9

Clinical Eponymic Signs.

(Continued from Page 177)

GROCCO'S SIGN—A paravertebral triangle of dullness in pleural effusion on the side opposite to that of the effusion.

GROSSMAN'S SIGN — Dilatation of the heart as a sign of early pulmonary tuberculosis.

GUBLER'S SIGN—A swelling on the wrist in lead-poisoning.

GUNZBERG'S SIGN—A resonant area between the gall-bladder and pyloris with localized borborygmi; seen in duodenal ulcer.

GUTTMAN'S SIGN — A humming sound heard over the thyroid in exophthalmic goiter.

GUYE'S SIGN — Aprosexia occurring in childhood with adenoid vegetations of the nasopharynx.

GUYON'S SIGN—Ballottement in cases of renal tumor.

HAHN'S SIGN—Persistent rotation of the head from side to side in cerebellar disease of childhood.

HALL'S SIGN — A tracheal diastolic shock sometimes felt in aneurysms of the aorta.

HARDY-BEHIER'S SYMPTOMS—See Behier-Hardy's Symptom.

HAUDEK'S SIGN—A diverticular projecting shadow in radiographs of penetrating gastric ulcer, due to settlement of bismuth in pathological niches of the stomach wall; not possible in flat ulcer.

HEBERDEN'S SIGN—Nodes on the sides of the distal phalanges of the fingers, commonly ascribed to gout.

HEGAR'S SIGN—Softening of the lower segment of the uterus; an indication of pregnancy.

HEIM-KREYSSIG'S SIGN — See Kreyssig's Sign.

HENNEBERT'S SIGN—In the labyrinthitis of congenital syphilis, compression of the air in the external auditory canal produces a rotary nystagmus to the diseased side; rarefaction of the air in the canal produces a nystagmus to the opposite side.

HERNIG-LOMMEL'S SIGN — An exaggeration of the normal respiratory increase and expiratory decrease in the frequency of the heart's action.

HERTZEL'S SIGN—If in the normal person the circulation of both legs and one arm is entirely stopped by pneumatic pressure, the blood-pressure in the other arm rises about 5 mm. Hg. In arteriosclerosis, however, there is a rise as high as 60 mm. Hg.

HERYNG'S SIGN—An infraorbital shadow observed on introducing an electric light into the mouth in empyema of the antrum of Highmore.

HICK'S SIGN (Braxton) — Intermittent uterine contractions beginning at the end of the third month of pregnancy; they may also be produced by tumors distending the uterus.

HOCHSINGER'S SIGN — The existence of indicanuria in tuberculosis of childhood.

HOFFMAN'S SIGN—Increase of the me-

chanical irritability of the sensory nerves in tetany.

HOOVER'S SIGN—In the normal state or in genuine paralysis, if the patient, lying on a couch, is directed to press the leg against the couch, there will be a lifting movement seen in the other leg. This phenomenon is absent in hysteria and malingering.

HOPE'S SIGN—Double heart-beat in aortic aneurysm.

HOWSHIP-ROMBERG'S SIGN — See Romberg's Sign.

HUCHARD'S SIGN — The difference in the pulse between the standing and recumbent posture is less in persons with arterial hypertension and may even be the reverse of that of the normal condition.

HUETER'S SIGN — Absence of transmission of osseous vibration in cases of fracture with fibrous interposition between the fragments.

HUTCHINSON'S SIGN — (1) Interstitial keratitis and a dull red discoloration of the cornea in inherited syphilis.

ITARD-CHOWLEW'S SIGN—Anesthesia of the tympanic membrane is otosclerosis.

JACCOUD'S SIGN—(1) A lateral displacement and rolling movement of a portion of the thoracic wall in adherent pericardium, especially when this is associated with extrapericardiac adhesions. (2) Prominence of the aorta in the region of the suprasternal notch in cases of aortic dilatation.

JACKSON'S SIGN—(1) Of cardiac failure; a discrepance between the pulse-rate and that of the heart-beat. (2) Prolongation of the sound of expiration over the part of the lung affected with tuberculosis.

JACQUEMIN'S SIGN — Blue coloration of the vaginal mucosa appearing about the twelfth week of pregnancy.

JADELOT'S SIGN — Lines of the face in young children supposed to be indicative of disease; the genal nasal labal and oculozygomatic lines.

JAFFE'S SIGN—The flow of pus from a tube inserted into a subdiphragmatic abscess is more abundant during inspiration than during expiration; if the collection is thoracic, the inverse holds true. Paralysis of the diaphragm prevents the manifestation of this sign.

JELLYNECK'S SIGN—The brownish pigmentation which occurs in many cases of hyperthyroidism.

JOFFROY'S SYMPTOM — (1) Absence of facial contraction when the patient suddenly turns his eyes upward; in exophthalmic goiter. (2) Rhythmic twitching of the glutei on pressure upon the gluteal region in cases of spastic paraplegia and sciatica.

JOHNSON'S SIGN—Alterations of color of the vaginal cervix from violet to pink, with alteration of consistence from hard to soft. A sign of early pregnancy.

JORISENNE'S SIGN — Non-acceleration of the pulse on changing from the horizontal to the erect position; a sign of pregnancy.

JOSSERAUD'S SIGN — A peculiar loud, metallic sound, heard over the pulmonic area, and preceding the friction sound in acute pericarditis.

JURGENSEN'S SIGN—Delicate crepitation of pleural tubercles sometimes heard in auscultation in acute pneumonic phthisis.

KEEN'S SIGN—Increased diameter thru the leg at the malleoli in Pott's fracture.

KEHR'S SIGN—Severe pain in the left shoulder in some cases of rupture of the spleen.

KELLOCK'S SIGN—Increase of the vibration of the ribs on sharp percussion with the right hand, the left hand being placed firmly on the thorax under the nipple; a sign of pleural effusion.

KERNIG'S SIGN—Contracture or flexion of the knee and hip-joint, at times also of the elbow, when the patient is made to assume the sitting posture; it is noted in meningitis.

KOCHER'S SIGN—A symptom of exophthalmic goiter; the examiner places his hand on a level with the patient's eyes and then lifts it higher; the patient's upper lid swings up more quickly than does his eyeball.

KOENIG'S SYMPTOM-COMPLEX — Alternation for a long period of constipation and diarrhea, and irregular attacks of colic

which are generally of short duration and terminate suddenly. During these attacks the abdomen is distended, there exists frequently a visible peristalsis, and a loud gurgling is heard in the ileocecal region. These symptoms are characteristic of tuberculous stenosis of the cecum.

KOPLIK'S SIGN OR SPOTS—Minute bluish-white spots surrounded by a reddish areola; they are observed on the mucous membrane of the cheeks and the lips of the patient during the prodromal stage of the measles.

KORANYI'S SIGN—See Grocco's Sign.

KREYSSIG'S SIGN—Retraction of the epigastrium and the contiguous portions of the false ribs with each systole, in adherent pericardium.

KRISOWSKI'S SIGN—See Silex's Sign.

KUESTER'S SIGN—A cystic tumor felt in the median line in front of the uterus is a dermoid cyst.

KUSSMAUL'S SYMPTOM—Swelling of the cervical veins during inspiration in adherent pericardium and mediastinal tumor.

LABORDE'S SIGN—See Cloquet's Needle Sign.

LAENEC'S SIGN — The occurrence of rounded, gelatinous masses (Laenec's perles) in the sputum of bronchial asthma.

LANDOLFI'S SIGN—Systolic contraction of the pupil and diastolic dilatation, seen in aortic insufficiency.

LANDOU'S SIGN—Inability to grasp the uterus bimanually in the presence of slight ascites.

LANGORIA'S SIGN—Relaxation of the extensor muscles of the thigh. A symptom of intracapsular fracture of the femur.

LARCHER'S SIGN — Grayish, cloudy discoloration of the conjunctivæ of the eye that are speedily blackened; a sign of death.

LASEGUE'S SIGN—(1) Incapacity of the anesthetic hysteric individual to move the extremity which he is prevented from seeing. (2) To differentiate between sciatic and hip-joint diseases; in case of the former, flexion of the thigh upon the hip is painless or easily accomplished when the knee is bent.

LAUGIER'S SIGN—A condition in which the styloid process of the radius and ulna are on the same level; seen in fracture of the lower part of the radius.

LEBHARDT'S SIGN—See Jacquemin's Sign.

LEGENDRE'S SIGN—Greater resistance on the unaffected side in the closed eyelid to its being raised by the examiner's finger, in facial hemiplegia.

LEHMAN'S SIGN—In the administration of chloroform, to prognosticate as to a ready or difficult anesthesia. If the eyelids closed by the anesthetizer reopen at once wholly or in part, the anesthesia will be difficult. The eyes will remain closed from the beginning in those who take the chloroform well.

LEICHTENSTERN'S SIGN—In cerebrospinal meningitis, tapping lightly any bone of the extremities causes the patient to wince suddenly.

LENHOFF'S SIGN—In cases of echinococcous cyst on deep inspiration a furrow forms above the tumor between it and the edge of the ribs.

LESIEUR'S SIGN—Impaired resonance over the right lower thorax posteriorly, occurring in typhoid fever.

LESIEUR-PRIVY SIGN—The reaction of the sputum to tests for albumin; the presence of albumin (positive reaction) indicating pulmonary inflammation.

LEUDET'S SIGN—A fine crackling sound in the ear, audible to both the patient and the examiner, heard in catarrhal and nervous disorders of the ear.

LEVASSEUR'S SIGN—The failure of the scarificator and the cupping-glass to draw blood; a sign of death.

LEYDEN'S SIGN—In cases of subphrenic pyopneumothorax manometric observation shows that the pressure in the abscess cavity rises during inspiration and falls during expiration. The reverse was held by Leyden to occur in true pneumothorax.

LICHTHEIM'S SIGN—In subcortical aphasia, although the patient cannot speak, he is able to indicate with his fingers the number of syllables in the word he is thinking of.

LITTEN'S SIGN—"Diaphragm phenome-

non." Retraction of the lateral portion of the thorax, where the diaphragm is inserted the retraction portions being lowered during inspiration and rising during expiration. It is absent in pleuritic adhesions, effusion into the pleural cavity, empyema, etc.

LLOYD'S SIGN—A symptom of renal calculus, consisting of pain in the loin on deep percussion over the kidney, even when pressure causes no pain.

LOMBARDI'S SIGN — The appearance of venous varicosities in the region of the spinous processes of the seventh cervical and first three thoracic vertebrae; seen in early pulmonary tuberculosis.

LOREN'S SIGN—Ankylotic rigidity of the spinal column, especially of the thoracic and lumbar segments; sometimes seen in incipient phthisis.

LOWY'S SIGN—Marked dilatation of the pupil on the instillation of adrenalin into the conjunctival sac; seen in pancreatic insufficiency.

LUCAS' SIGN—Distention of the abdomen, an early sign of rickets.

MACEWEN'S SYMPTOM—Increased resonance on combined percussion and auscultation of the skull in certain gross lesions of the intracranial contents—*e. g.*, in cerebral abscess or overdistended lateral ventricles.

MAGENDIE-HERTWIG'S SIGN—Deviation of the eye in which one eye is directed higher than the other.

MAGNAN'S SIGN — An hallucination of general sensation which takes the form of the sensation of a round foreign body beneath the skin, noted in chronic cocainism.

MAGNUS'S SIGN—After death the light ligation of a finger causes no visible change in its distal portion.

MAHLER'S SIGN—A steady increase of pulse-rate without corresponding elevation of the temperature. Seen in thrombosis.

MAISSONEUVE'S SIGN — Marked hyperextensibility of the hand; a symptom of Colles' fracture.

MANN'S SIGN—Diminished resistance of the scalp to the galvanic current in traumatic neuroses.

MANNABERG'S SIGN — Accentuation of the second sound of the heart in abdominal disease, especially in appendicitis.

MANNKOPF'S SIGN, M.-RUMPF'S SIGN—Acceleration of the pulse on pressure over painful points in traumatic neuroses.

MARIE-KAHLER'S SYMPTOM-MARIE'S SIGN—Tremor of the extremities or the whole body in exophthalmic goiter.

MASINI'S SIGN—Marked dorsal extension of the fingers and toes in mentally unstable children.

MATHIEU'S SIGN — A splashing sound heard on rapid percussion in the region about the umbilicus in complete intestinal obstruction.

MAYO'S SIGN—Relaxation of the muscles controlling the lower jaw; indicative of profound anesthesia.

MAYOR'S SIGN—The sound of the fetal heart-beat in pregnancy.

MCBURNEY'S SIGN — Tenderness at a point midway between the umbilicus and the anterior superior spine of the ileum; it is seen in appendicitis.

MCCLINTOCK'S SIGN—A pulse-rate exceeding 100 an hour or more after childbirth. It points to postpartum hemorrhage.

MELTZRE'S SIGN—Normally, on auscultation of the heart (at the side of the xiphoid appendix) there is heard, after swallowing, a first sound produced by the flowing of fine drops, and six or seven seconds after a glou-glou. According to Meltzer, the second sound fails in the case of occlusion or pronounced contraction of the lower part of the esophagus.

MENDEL'S SIGN—An area on the epigastrium about the size of a half dollar, tender to percussion; occurring in gastric and duodenal ulcer.

MENDEL-BECHTEREW'S SIGN—Tapping of the toe tendons produces extension of the great toe.

MEUNIER'S SIGN OF MEASLES—A daily loss of weight noticed four or five days after contagion. This may amount to 50 gms. daily, commencing five or six days before the appearance of catarrhal or febrile symptoms.

MEYER'S SIGN—Formication of the hands and feet in the eruptive stage of scarlet fever.

MIRCHAMP'S SIGN — A sign of mumps when a sapid substance, such as vinegar, is applied to the mucous membrane of the tongue, a painful reflex secretion of saliva in the gland about to be affected.

MOEBIUS' SIGN—Inability to retain the eyeballs in convergence in exophthalmic goiter.

MONTEVERDE'S SIGN—Failure of any response to the subcutaneous injection of ammonia. A sign of death.

MOSZKOWICZ'S SIGN—A sign of vascular gangrene. On making a circular compression of the base of the limbs by elastic bands and then, after a few minutes, releasing the pressure, the skin which has been rendered anemic will become red. If the limbs are healthy the redness appears with the same intensity and rapidity on each side. On a gangrenous limb there is usually a slower and less extensive hyperemia than on the healthy one.

MUELLER'S SIGN—Pulsation of the tonsils and the soft palate in cases of aortic insufficiency.

MURPHY'S SIGN—A sign of gall-bladder disease, consisting of inability of the patient to take a deep inspiration when the physician's fingers are hooked up deep beneath the right costal arch, below the hepatic margin.

MUSSET'S SIGN—Rhythmic jerking movement of the head, seen in cases of aortic aneurysm and aortic insufficiency.

DEMUSSEY'S POINT OR SYMPTOM—"Bouton diaphragmatique." A point intensely painful on pressure at the intersection of a line continuous with the left border of the sternum and of another forming a prolongation of the tenth rib. It is noted in diaphragmatic pleurisy.

NAUNYN'S SIGN—A sign of cholecystitis, consisting in deep tenderness, when at the end of a full inspiration the examiner's fingers are thrust upward beneath the costal arch at the outer limit of the right epigastrium.

NERI'S SIGN—A sign of organic hemiplegia, consisting in the spontaneous bending of the knee of the affected side as the leg is passively lifted, the patient being in the dorsal position.

NIKOLSKY'S SIGN—A condition in which the outer layer of the skin is easily rubbed off by slight injury.

NOTHNAGEL'S SYMPTOM — Paralysis of the facial muscles, which is less marked on voluntary movements than on movements connected with the emotions. This symptom has been noted in cases of tumor of the optic thalamus.

OLIVER'S SYMPTOM — Pulsation of the larynx elicited by grasping the larynx between the thumb and index finger and pressing upward, the patient being in the erect position; it is noted in aneurysms of the aortic arch, and in mediastinal tumors that bring the arch of the aorta in contact with the left bronchus.

OLIVER-CARDARELLI'S SYMPTOM—See Oliver's Symptom.

OLSHAUSEN'S SIGN—When a tumor is found in young unmarried women lying anterior to the uterus, it is likely to be a dermoid cyst.

ONANOFF'S SIGN — Contraction of the bulbo-cavernosus muscle on compressing the glans penis; said to be indicative of dementia praecox.

(To be continued.)

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Vanderol.

A rather expensively prepared advertising card, forwarded by a medical officer in France to the Surgeon General's office in Washington, read: Urinary Duets—Ancient and Recent Runnings—Cystitis, Prostaticis, Filaments—Speedy and Radical Recovery by means of the Vaderol—Used in the Urologicals Establishments of the Armies. The card is an interesting evidence of the attempt of a French patent medicine maker to exploit the English speaking soldier now in France.—Journal A. M. A., July 20, 1918, p. 215.

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We do not carry announcements in our advertising pages which we could not endorse editorially. We try to be consistent.

THE JOURNAL
of The
Kansas Medical Society

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The Birth Control Problem.

Some literature and a questionaire, recently mailed out by the National Birth Control League, would suggest that sooner or later the merits of this question will require very careful consideration. The fact that thirteen of the fifteen members of the executive committee are women suggests that the agitation for greater freedom in birth control will probably grow with the spread of woman suffrage.

The objects of the association, as stated on the letter heads, are: 1. To secure the repeal or amendment of all laws prohibiting the giving out of information concerning methods of birth control through the prevention of conception.

2. To collect and distribute facts in regard to the legal status of birth control education in the United States and other countries.

We do not question the altruism of those who are engaged in this movement, nor do we doubt their philanthropic motives, but we wonder at the apparent oversight of the moral status of the legislation now in force, and of the moral and economic elements which lead to its adoption.

As a basic argument for the repeal of all such legislation the following statement is printed on the letterheads and referred to in the questionaire: "Birth control is race conservation. It lowers the birth rate, but lowers the death rate and infant mortality still more. Fewer people are born, but more survive."

One who has had no occasion or opportunity to study the evidence upon which the above statement is based would hardly be justified in denying its truth, but on the other hand one who is accustomed to think carefully would hesitate to accept it as true without an intimate knowledge of the facts. It would seem that in order that birth control should also be race conservation there must also be control of "birth control."

The questionaire is evidently intended to determine how widespread is the sentiment in favor of birth control. The statements upon which the questions are based and the questions themselves are stated in such a manner as to encourage favorable replies. The first implied statement is that birth control information uniformly results in a healthier, happier nation and a population which is increasing without waste. We have no means at hand for determining the accuracy of this statement. It is rather a broad statement and would require a very careful consideration of all the elements concerned in making health and happiness for its substantiation.

The next implied statement is that the best modern scientific research has proved that wisely chosen contraceptive methods are not injurious to health. Reports of any such scientific research have certainly not been widely published. It would be interesting to know by whom and how such research was conducted. We doubt if any such research would be of greater value than the observations of medical men in general practice, and we doubt if they would very generally agree that the contraceptive methods in most common use are not injurious. Most every practitioner has had reason to condemn these methods as dangerous to health. Most every one has had cases in which the injury from such methods was very pronounced and unmistakable.

Another of the implied statements, that

the present law is constantly broken by hundreds of thousands of the well-to-do, while the poor who most need the information are left in ignorance, is no doubt partially true, if it is meant that these hundreds of thousands use some method of contraception. If it is meant that the well-to-do are lawbreakers by disseminating knowledge of such methods among themselves, it is also probably true. But it is not clear how poverty exempts so large a class from this form of malfeasance. We venture the assertion that the poorer classes are quite familiar with the methods most commonly used by a large part of the hundreds of thousands of the well-to-do, but they are either more considerate of their health and happiness or more indifferent to the inconveniences of frequently recurring pregnancy.

There is but one point in this questionaire upon which we can agree, and that is that there should be definite instruction on this subject given in medical schools.

In all the arguments presented the possible effects of the free dissemination of "birth control" information upon the moral and social life of the people has been ignored. Is it no longer of importance? We must assume that when the laws which prohibit the dissemination of such knowledge were passed it was because such knowledge was considered dangerous to the moral or economic welfare of the people. If it has been shown that the economic conditions of a people are bettered by some system of birth control, we have not yet the evidence that our moral status will also be improved.

There are many good men and good women who are virtuous for virtue's sake. There are many people of both sexes who are virtuous because of their fear of exposure, who stand in greater awe of a possible inopportune pregnancy, and consequent exposure and social ostracism, than of all the laws of God or man.

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Unreliability of the Mouth Temperature.

As a guide to the presence or absence of pyrexia the mouth temperature may be too confidently relied upon. In cases of mild infections the mouth temperature may perhaps indicate, with sufficient accuracy, the amount of pyrexia, but there are cases, especially in the more severe infections, in which the mouth temperature is quite unreliable.

In some hospitals rectal temperatures are taken as a routine practice, and it is generally believed that the rectal temperature should be higher than that of the mouth. A difference of one-half degree is generally allowed.

In a series of cases, with slight or no rises of temperature, records of both mouth and rectal temperatures were made. The difference was variable. In part of the cases the rectal temperature was as much as a half degree higher all of the time. In some other cases the rectal would sometimes be higher and sometimes lower than the mouth, but never more than a half degree. In a part of the cases the mouth temperature was invariably higher than the rectal. The variation was never very marked and the difference between the two temperatures would ordinarily not be of great importance.

There are cases, however, in which the difference between the mouth and rectal temperatures may exceed five degrees, and such cases may be easily overlooked if one confines himself too closely to mouth temperatures. The writer's attention was called to this in a case of septic endocarditis. At the hospital, rectal temperatures ranging from 102 to 103.5 degrees had been recorded since the patient's admission. On the third day a relieving nurse recorded a mouth temperature of 98.2 degrees. There being no apparent change in the patient, a rectal temperature was taken and found to be 103.4 degrees. A continued comparison of mouth and rectal temperatures showed a very marked variation, but the rectal temperature ranged from two to five degrees higher than the mouth temperature.

The writer has observed this very marked difference between the mouth and

rectal temperatures in several similar cases since then and in one case of pulmonary abscess.

It is probably true that in the majority of cases there will be very little difference, and it is not always convenient to get a rectal temperature in every case, but it may be well to suggest that when the mouth temperature is lower than the conditions seem to justify, a rectal temperature should be taken.

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Vagotonia.

Vagotonia, or Vagotony, defined as a hypertonicity or irritation of the nerves comprising the autonomic nervous system, but especially of the vagus, seems to be one of those vague uncertainties in the makeup or functioning of our anatomical structure—possibly an inferiority in construction—which gives rise to a great variety of symptoms.

It was described by Spitzig in 1914, by Wolfsohn in the same year, and by Held and Gross in 1916. Smith, in 1917, called attention to the resemblance of the symptoms of anaphylaxis to those of vagotonia, and it has been suggested that diet may be a factor in its cause. Among other possible causes have been mentioned ductless gland disturbances, particularly hyperthyroidism. Also chronic bacterial infections, such as tuberculosis, is mentioned as a cause. Gley says it is caused by the excessive secretion of autonomotropic hormones accompanied by a deficient secretion of sympathicotropic hormones.

Among the many manifestations of vagotonia are mentioned: Mild spasm of convergence, salivation, tendency to sweating, dermographism, cardiac neurosis, vagotonic goiter heart, bronchial asthma, laryngospasm, cardio and esophagospasm, vagotonic forms of stomach unrest, gastrosuccorrhea, hypersecretion of stomach, anesthetic pharynx of vagotonics, peristaltic unrest of intestine, diarrhea, spastic constipation, mucous colitis, anal cramps, erections and pollutions, spasm of gallbladder and ducts not due to stone, reflex anuria, orthostatic albuminuria, oesinophilia.

Belladonna in some form in full doses seems to promise the most in the line of treatment. Constipation should be relieved and the diet regulated.

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In a little book for nurses recently published, the reader is shown, by means of a series of pictures, how to give the morning bath. Every step in the process is shown—but one. It reminds one of the story of the girl who was too modest to undress for the bath, and the doctor's advice to her.

Few nurses will have difficulty in learning how to bathe arms, legs, chest and abdomen, but many of them, at first, approach the bathing of a part of the body, neither mentioned nor illustrated in the little book of instructions, with great timidity. They do not know what to do until they have been told. Books that tell them what to do and how to do it should tell them how to do all the things they are required to do.

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Dr. Edward Jackson, 318 Majestic Building, Denver, Colorado, is trying to collect statistics with regard to the cases of injury to sight occuring from the total eclipse of the sun in the United States on June 8. Those who have seen such cases should make a detailed report of the same and forward it to Dr. Jackson.

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Dr. H. L. Cobean, W. M. Martin and J. C. Caldwell, of Wellington, have been commissioned Captains in the Medical Officers Reserve Corps. Dr. Cobean is already at Fort Riley.

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The following physicians of Sumner County have applied for commissions and have been examined: Dr. H. A. Vincent, Perht; Dr. E. F. Clark, Mayfield; Dr. R. H. Downing, Wellington; Dr. L. S. Copland, Wellington.

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A popular writer in the Saturday Evening Post, to emphasize a point, relates

the story of the battered garbage pail and the ten-dollar silk hat that were washed down the river in a Mississippi flood. The garbage pail called out to the aristocratic tile, "How soon will we get to Paducah?" The silk hat replied, "Paducah is ten miles south! But what in hell do you mean by we?"

One can hardly question the geographical accuracy of a ten-dollar silk hat that speaks the American language so well, but just as a matter of history one would like to know in just what part of the Mississippi that conversation occurred.

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The following physicians of Kansas have been reported as having accepted commissions in the army and navy since June 1:

C. A. McGuire, Topeka.
C. E. Coburn, Kansas City.
J. A. Fulton, Kansas City.
G. M. Gafford, Kinsley.
W. R. Brady, Parsons.
F. P. Mann, Valley Falls.
F. B. Campbell, Esbon—Navy.
C. W. Rose, Floral—Navy.
L. J. DeBacker, St. Marys—Navy.
O. W. Miner, Sublette—Navy.
L. L. Bresette, Topeka—Navy.
L. R. Hazard, Wichita—Navy.
W. B. Burr, Longton.
N. E. Naylor, Burlingame.
W. H. Iliff, Crestline.
L. J. Pierce, Englewood.
J. B. Edwards, Garden City.
C. M. Gibbs, Greenfield.
W. J. Gates, Kansas City.
C. E. Kinley, Kansas City.
L. C. Lewis, Kansas City.
J. H. Rinehart, Quinter.
H. C. Snyder, Seneca.
H. D. Thomas, Shawnee.
W. L. Butler, Stafford.
R. B. Stewart, Topeka.
J. M. Marks, Valley Falls.
F. J. Austin, White Cloud.
A. L. Crittenden, Wichita.
E. H. Schlegel, Wichita
F. C. Cave, Winfield.
H. M. .Barnes, Blue Mound.
W. W. Reed, Blue Rapids.
L. W. Baxter, Columbus.
F. G. Poutre, Horton.
W. S.. Hudiberg, Independence.
J. W. Faust, Kansas City.
C. H. Hobson, Kansas City.
E. A. Reeves. Kansas City.
J. E. Smith, Kansas City.
J. S. Rushton, Morrill.
A. M. Dawson, Topeka..
F. L. Loveland, Topeka..
H. L. Cobean, Wellington.
W. M. Martin, Wellington.
C .A. McKinley, Wichita.
S. W. Connor, Atchison—Navy.
A. C. Clasen, Rosedale—Navy.
A. A. Shelley, Galena.
L. D. Mills, Greeley.
R. H. Miller, Greensburg.
H. Wilkinson, Kansas City.
W. Lapat, Larned.
C. H. Smith, Pittsburg.
W. H. Updegrove, Pittsburg.
H. W. Horn, Wichita.
A. D. Jones, Wichita.
F. J. Walker, Wichita.
A. W. Little, Kansas City—Navy.

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Rehabilitation of Our Wounded.

Perhaps none of the various uses to which the proceeds of the Liberty Loan are to be devoted appeals more strongly to the American people than the rehabilitation and reeducation of our wounded men. To teach these men, to train and fit them for useful and gainful occupations, when by reason of loss of sight or limbs or other injuries they are rendered unable to pursue ordinary vocations, is a work in which every American has a heartfelt interest.

Compensation will be allowed them and family allowances will be paid their families as if they were in actual service while they are taking the training, and every method known to science will be used to restore our wounded men to health and usefulness.

This work has been delegated by Congress to the Federal Board for Vocational Education. The board publishes at Washington a monthly bulletin, dealing with its

work, called The Vocational Summary, which will be sent free to anyone upon request.

The Soldier's Chances.

Great as the danger and large as the losses in the aggregate, the individual soldier has plenty of chances of coming out of the war unscathed, or at least not badly injured.

Based on the mortality statistics of the allied armies, a soldier's chances are as follows:

Twenty-nine chances of coming home to one chance of being killed.

Forty-nine chances of recovering from wounds to one chance of dying from them.

One chance in 500 of losing a limb.

Will live five years longer because of physical training, is freer from disease in the army than in civil life, and has better medical care at the front than at home.

In other wars from ten to fifteen men died from disease to one from bullets; in this war one man dies from disease to every ten from bullets.

For those of our fighting men who do not escape scatheless, the Government under the soldier and sailor insurance law gives protection to the wounded and their dependents and to the families and dependents of those who make the supreme sacrifice for their country.

Higher Rank for Medical Officers.

The President has signed the army appropriation act which carries with it a large number of changes in the military establishment of the United States. The act appropriates $12,085,000,000 which is an increase of $44,000,000 above the aggregate authorized in the House bill. Among the changes introduced by the bill is an increase in the Medical Department which includes one assistant surgeon general, for service abroad during the present war, with the rank of major general, and two assistant surgeon generals, with the rank of brigadier general, all of whom shall be appointed from the Medical Corps of the regular army. The President is also authorized to appoint two major generals and four brigadier generals in the Medical Department of the national army. As the law was finally enacted, only half the number of generals were provided for the national army asked for in the Owen bill. A very important change is that which authorizes the promotion of members of the Medical Reserve Corps to the rank of colonel. Heretofore they could not be given a higher rank than that of major. In the course of the hearing before the Senate Committee on Military Affairs, Surgeon General Gorgas said that the most essential feature of the Owen bill was that which provided for an increase in rank to colonel in the Medical Reserve Corps and this has been covered in the amended measure.—New York Medical Journal.

BOOKS.

Materia Medica and Therapeutics for Nurses.
By John Foote, M.D., Assistant Professor of Therapeutics and Materia Medica, Georgetown University School of Medicine; Instructor in Materia Medica and Therapeutics, Providence Hospital Training School for Nurses. Third edition revised, enlarged and reset. Published by J. B. Lippincott Company, Philadelphia. Price, $1.75.

The third edition of this book is now on the market. It has been revised to conform to the last revision of the U. S. Pharmacopoeia. It is arranged especially for the instruction of nurses. Part I is devoted to definitions and weights, dosage, methods of administration of medicines, preparation of antiseptic and other solutions, and a description of the action of medicines. In the third part of the work are a number of lists and tables which are convenient for ready reference.

Oral Sepsis and Its Relation to Systemic Disease.
By William W. Duke, M.D., Ph.B., Professor of Experimental Medicine in the University of Kansas School of Medicine; Professor in the Department of Medicine in Western Dental College; Visiting Physician to Christian Church Hospital; Consulting Physician to Kansas City General Hospital, Kansas City, Mo., and to St. Margaret's Hospital, Kansas City, Kan. With 170 illustrations. Published by C. V. Mosby Company, St. Louis.

A considerable number of our members have heard Dr. Duke's lectures on this subject and will be very glad to know that

the report of his work in this line is available in book form. His conclusions are drawn from more than a thousand cases in which dental roentgenograms were made, as a part of the routine of examination—and in all more than eight thousand films were taken.

Dr. Duke has presented some very striking facts for consideration, and in a large per cent of cases the pathologic relationship was demonstrated in the relief afforded by removal of septic mouth conditions.

The Practice of Pediatrics.

By Charles Gilmore Kerley, M.D., Professor of Diseases of Children, New York Polyclinic Medical School and Hospital. Second edition, revised and reset. Octavo of 913 pages, 136 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $6.50 net.

The second edition of Kerley's Pediatrics has just been received. It has been quite thoroughly revised. About twenty-five new articles have been added, some old matter has been cut out and many of the chapters have been rewritten. It is a very complete text-book and it is gratifying to see that the author and the publishers believe in keeping it up to date.

A Treatise on Clinical Medicine.

By William Hanna Thomson, M.D., LL.D., formerly Professor of Practice of Medicine and of Diseases of the Nervous System in the New York University Medical College; ex-President of the New York Academy of Medicine, etc. Second edition, revised. Octavo of 678 pages. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $5.50 net.

The dominant feature of modern medical literature seems to be conciseness or bluntness. A succession of concise statements of facts may facilitate the assembly of information for immediate purposes, but it is unattractive and laborious reading.

Thompson is one of the few modern writers who can present the facts in medicine in a really attractive form. His is something of a narrative style, with a little of his own experience, now and then, to more fully impress one with his conclusions. It is not only a very thorough and complete text, but a very readable book.

Principles of Surgical Nursing.

A Guide to Modern Surgical Technic. By Frederick C. Warnshuis, M.D., F.A.C.S., Visiting Surgeon, Butterworth Hospital, Grand Rapids, Mich.; Chief Surgeon, Pere Marquette Railway. Octavo of 277 pages with 255 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.50 net.

Just how much the student nurse should be taught of the principles and practice of medicine and surgery must some time be determined and a standard course adopted. At this time there are numerous text-books for the nurses' training course on the market, and each author seems to have determined for himself how much of his subject the nurse should know and how it should be presented.

Dr. Warnshuis, in his text-book on Surgical Nursing, has solved the problem by limiting his instruction to the work the nurse is required to do. He is unusually explicit and thorough and has used numerous illustrations to elucidate the text. The details of the morning bath are told in a series of twenty-seven pictures.

Principles of Hygiene.

For Students, Physicians, and Health Officers. By D. H. Bergey, M.D., Assistant Professor of Hygiene and Bacteriology, University of Pennsylvania. Sixth edition thoroughly revised. Octavo of 543 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $3.50 net.

There is, perhaps, no subject of more vital importance to the profession and the people, at this time, than that of Hygiene. Much general instruction along this line is being offered the public by various organizations, and thoroughly reliable text-books on the subject should be well received.

Bergey's Principles of Hygiene, now in its sixth edition, presents a very comprehensive review of the following subjects: Air, ventilation, heating, water and water supply, garbage, sewage, food and dieting, exercise, clothing, personal hygiene, military hygiene, naval hygiene, soil, habitation, vital causes of disease, disinfection, quarantine, vital statistics.

A Text-Book of Obstetrics.

By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania. Eighth edition, revised and reset. Octavo of 863 pages, with 715 illustrations, 38 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $5.00 net.

From constant perusal of the current

medical literature one is not impressed with any very marked progress or change in the practice of obstetrics, but such new ideas as seem worthy of consideration, or promise endurance, have been included in the recently revised edition of Hirst.

Several very elaborate series of illustrations, showing in detail the steps of delivery in various malpositions, add materially to the value of the book.

SOCIETY NOTES.

SUMNER COUNTY SOCIETY.

Epidemiologists from the Surgeon General's office, Capt. Knowlton and Lieut. Shelton, and Dr. Sippey of the State Board of Health, brought their messages to the counties of Harper and Sumner, speaking to the county and city commissioners and the medical men, at the regular meeting of the Sumner County Medical Society, July 17.

Dr. Sippey explained the relationship of the State and Nation in the fight for disease prevention.

Lieut. Shelton spoke of the dangers to the army from general infectious diseases brought from different parts of the country and stressed the point that we acquire more or less immunity to our own germs, our family's germs, and the community's germs, but have no immunity to the germs bred in Nebraska or Iowa or even other parts of our own state. If such diseases as mumps and measles are controlled, preventing a lowering of the resistance of the men in the army by these diseases, the individuals will soon acquire an immunity to the germs of the army, and thus epidemics will be prevented.

Capt. Knowlton showed how to prevent venereal diseases in the home town and thus keep them away from the army. It is briefly:

1. Health officer must have information sufficient to convince him that the person may be, or is, diseased and is not living in a manner to prevent its spread.

2. Health officer issues an order for the sheriff to bring this party to him or his representative for examination—they must make cultures.

3. If the cultures are positive the party must be quarantined under the care of the sheriff.

4. Females may then be sent to the State Industrial Farm at Lansing.

Capt. Caldwell having received his commission in the Reserve Corps, resigned his position as secretary of the society and Dr. T. H. Jamieson was elected to fill the vacancy.

CENTRAL KANSAS SOCIETY.

The regular meeting of the Central Kansas Medical Society was held at Russell, Kansas, July 5, 1918. Capt. F. S. Hawes, M.R.C., was the honored guest, he being home on a furlough previous to going overseas. Dr. J. B. Carter called the meeting to order at 8:30 p.m. Dr. Reitzel not being present, Dr. Turgeon was appointed acting secretary for the meeting.

The following program was carried out:

"The Attitude of the A.M.A. Regarding Enlistments," Dr. Alfred O'Donnell, Ellsworth, Kan.

"We Men Who Have Sent In Our Applicataions," Dr. Blake, Ellis, Kan.

"What About Those of the Draft Age?" Dr. Leo V. Turgeon, Wilson, Kan.

"What Rank Are They Going to Give Us?" Dr. Jameson, Hays, Kan.

"Dr. Hawes as a Fellow Physician," Dr. H. Z. Hissem, Ellsworth, Kan.

"Some Things We Learn and Unlearn in the Army Service," Capt. F. S. Hawes.

After the business meeting all the members were entertained at the home of Dr. C. Cramm.

Dr. N. Miller announced at the meeting that he had enlisted and would leave within a short time.

DR. L. V. TURGEON, Secretary.

DECATUR-NORTON COUNTY SOCIETY.

The Decatur-Norton County Medical Society met at Logan, Kansas, June 26, 1918. The program was as follows:

"Some Interesting Laboratory Findings

in Tuberculosis," W. S. Hunter.
Paper, F. E. Richmond.
"The Selective Draft," W. C. Lathrop.
"Cholera Infantum," E. L. Morgan.
Round Table.

C. S. KENNEY, *Secretary.*

MEDICAL DEFENSE BY THE KANSAS MEDICAL SOCIETY.

The Defense Fund of the Kansas Medical Society and the Defense Board, for its administration, were created by the House of Delegates at the annual meeting in May, 1911. The amendments to the Constitution and By-Laws, then adopted, are as follows:

RULES GOVERNING MEDICAL DEFENSE.

Extracts from Constitution and By-Laws as Amended at Kansas City, May, 1911.

A Medical Defense Board, consisting of three members of the Council, shall be elected at the annual meeting of the Council for a term of three years: Provided, that at the first election, one member shall be elected for the term of one year, one for the term of two years and one for the term of three years. The Medical Defense Board shall elect its own chairman, and the Board shall perform such duties as are provided in the By-Laws.

Section 2. The sum of two thousand dollars ($2,000.00) shall be set apart as a Medical Defense Fund, and there shall be added thereto annually the sum of 25 cents per capita of the membership of the Society. This fund shall be kept in the treasury of the Society and shall be subject to order drawn upon the Treasurer, signed by the Chairman of the Medical Defense Board and the President of the Kansas Medical Society.

Section 1. It shall be the duty of the members of the Defense Board severally or collectively to investigate all claims of malpractice made against members; to take full charge of all cases, which after investigation they will have decided to be proper cases for defense, and prosecute such defense to the end, pay all costs of such defense, but they shall not pay or obligate the Medical Defense Board of the Kansas Medical Society to pay any judgment rendered against any member upon the final determination of any such case. They shall be empowered to contract with such agents or attorneys as they may deem necessary.

Section 2. The assistance for defense, as herein provided, shall be available only for members of the Kansas Medical Society in good standing. No member shall be defended for an action unless he was a member of the Society and a resident of the state at the time when the alleged malpractice was committed.

Section 3. It shall he the duty of any member of this Society threatened with a suit or suits for malpractice, to immediately notify the president of the county society of which he is a member, who shall at once send him an application blank for the names of witnesses and so forth, and on receipt of this blank properly filled in, the president shall immediately appoint a committee of which he shall be the chairman and they shall proceed to investigate the charge made against such member.

Section 4. This committee shall examine the defendant member and his witnesses, if necessary under oath. If the committee shall agree that it is a case to be defended it shall so report to the chairman of the Defense Board of this Society. If this county committee shall decide that it is not a case to be defended, the defendant may appeal direct to the Defense Board of the Kansas Medical Society which shall in all cases have the final decision, whether a case is to be defended or not. The findings of these committees, if unfavorable, are to be communicated to the defendant alone.

Section 5. That present Chapters VIII, IX, X and XI be made Chapters IX, X, XI and XII respectively.

In addition to the rules adopted by the House of Delegates the Defense Board offers the following suggestions:

Whenever a member of the Society learns that he is likely to be sued for malpractice he should at once notify the chairman or other member of the Board, giving in as complete detail as possible all the facts in the case and the names and addresses of those interested as well as those who have knowledge of the case. This report will be immediately submitted to the attorney for the Board and he will advise the member as to how he should proceed. In many cases, with proper management, a suit may be prevented, with no expense and no discredit to the member.

Whenever a member of the Society learns that he is likely to be sued for malpractice, he should submit, as soon as possible, his application to the president of his county society and get a report from the investigating committee. The favorable action of this committee recommending that the suit be defended by the Society will often be sufficient to deter the plaintiff from further action.

No attorney should be employed by a member of the Society who intends to ask the assistance of the Defense Board in defending his case, until he has reported to the chairman or other member of the Board and received advice from him. An attorney is regularly employed by the Board to take charge of all its legal business and his immediate attention will be given to each case reported. Judgment cannot be taken in cases of this kind until thirty days after filing the suit. This gives abundant time for thorough examination and consultation before filing answer to the complaint.

The Defense Board prefers to take charge of all cases which it is asked to defend and thus avoid confusion and possible embarrassment to the work of its attorney.

Members of the Society who apply for assistance and who are protected by liability insurance should state this fact and give the name of the company in which the insurance is carried. While the Board is ready to lend its support and the that the Society should bear the burden of a advice and assistance of its attorney, when requested by members so protected, it does not feel defense otherwise provided for.

Since no case of malpractice can be maintained without expert evidence in support of it, we advise any member who is about to be sued to ascertain the names of the doctors who are supposed to support the contentions of the plaintiff and who are expecting to act as expert witnesses in the trial, and report the names to the chairman of the Defense Board.

As soon as a suit is filed where a poverty affidavit is filed instead of a bond or deposit for costs, the member should set about at once to

ascertain the financial condition of the plaintiff, in order that a motion for security for costs may be filed at once and the plaintiff compelled to give security, which often has a deterrent effect upon the prosecution.

In addition to the preceding suggestions, and by way of emphasis, the following points are especially to be borne in mind:

If you have need of the services of this Board, you should strictly comply with the foregoing instructions. The attorney will not undertake the defense of any member except upon the order of this Board, unless his services are retained by such member at private expense.

If suit against you is threatened, do not parley or in any way commit yourself. Do not show alarm, but be on guard. Usually such threats are bluffs, and if not "fed up," die of inanition.

Never compromise or settle a suit that is brought or threatened. This defense movement is not carried on merely for your individual benefit, but to inhibit the growing tendency to victimize our profession. A fight to the finish will better serve this purpose than a settlement, which latter is in most cases the end sought.

If you have a policy in some indemnity company, you will probably be consulted in the selection of an attorney to act for such company. You can help this Board and concentrate the forces of defense if you will nominate the attorney of this Board to be counsel for the indemnity company.

Do not employ a local attorney to take part in your defense without first consulting this Board. Our attorney will no doubt be glad to have you employ a local attorney at your own expense to coöperate with him, but it should be done only after a consultation with the Board. This Board has no funds with which to hire supplemental attorneys.

Be cautious not to commit yourself when a grievance against a colleague is related to you. Have a charitable and sympathetic feeling toward your fellow practitioner under such circumstances. Even if you are not on friendly terms with the accused, yet, for your own profession's sake, don't be the tool of the damage shark. You may be the next victim of some such malicious scheme.

Remember, in every malpractice suit there is to be found a physician openly or covertly acting in support of the plaintiff. Think twice before you assume the dirty role of the "nigger in the woodpile."

Don't let anybody disparage this coöperative defense movement of ours. Stand up for it. You are a partner in it. It is the one and only outstanding coöperative movement in which the profession of this state has ever engaged. When the solicitor for some indemnity company tries to shake your confidence in our defense plan, inform him that he is not only talking against your best interest by also against the interests of his own company as well, and invite him to change the subject.

Do not despise this defense movement because it does not provide supplemental lawyers and pay judgments. You have no right to expect all this for your little one dollar a year. The foreign companies which so obligingly assume these extra responsibilities will touch your pocketbook for a handsome sum as their price.

Medical Defense Board:

O. P. Davis, M.D., Chairman,
839 N. Kansas Ave., Topeka, Kansas;
D. R. Stoner, M.D., Quinter, Kansas;
W. F. Sawhill, M.D., Concordia, Kansas.

Color Blindness Among U. S. Seamen.

The importance of differentiating between those who are dangerously color-blind—that is, unable at all times to distinguish between red and green—and those who are only slightly color-blind, is brought out in a recent study conducted by the U. S. Public Health Service and reported in Public Health Bulletin No. 92.

The following classes are regarded as dangerously color-blind and therefore to be excluded from positions in which they would be required to read colored signal lights: (1) those who are able to see but three or less colors in the spectrum, (the normal person sees six or seven); (2). those who see more than three colors in the spectrum, but who have the red end so shortened as to prevent the recognition of a red light at a distance of two miles; and (3) those with a central scotoma (that is, a blind or partially blind area in the field of vision) for red and green.

It was concluded that this class of persons could be distinguished from those harmlessly color-blind by the use of the Edridge-Green color lantern, which was found preferable to colored yarns. The theories on which the color lantern is based are given in detail in the publication.

Another feature of the investigation was the study of the prevalence of color-blindness. Excluding those able to distinguish five colors in the spectrum, it was found that color-blindness occurs in about 8.6 per cent of men and 2.2 per cent of women. Color-blindness of a degree dangerous in occupations requiring the recognition of colored signal lights was found to occur in about 3.1 per cent of men and 0.7 per cent of women. Among refractive conditions of the eye, color-blindness occurs least frequently in eyes apparently without demonstrative refractive error; it occurs most frequently in eyes showing mixed astigmatism..

The examinations were made as a part of other studies of the effect of illumination on vision, conducted as a part of an illumination survey of the Federal department buildings in Washington, D. C. One

thousand persons were tested with the Edridge-Green lantern to determine the value of the lantern and the effect, if any, of refractive conditions, lesions, and anomalies of the eye, and also of sex, upon different degrees of color perception.

A special study of the Jennings self-recording worsted test was also made, fifty persons being tested with this and other tests. The results with the Jennings test were found to be too inaccurate for most work, although it was found to be far superior to other tests in certain lines of work where great accuracy and the classification of color defects were not essential.

Prevention of Meningitis, Diphtheria and Other Infectious Diseases in the Army Cantonments.

Some exceedingly interesting work on the prevention of the infectious diseases originating in the nasopharyngeal tract is being done by army surgeons at various cantonments.

For instance, in an article on "Meningitis at Camp Greene," contributed by Capt. Paul G. Woolley, to the Journal of Laboratory and Clinical Medicine for April, the statement is made that "In the only organization which made use of systematic nasal sprays since the first of the year, not a single case (of meningitis) developed, and also that in those organizations in which sprays were resorted to after the appearance of the disease no other cases appeared." The spray used at this camp was Dichloramine-T. Captain Woolley says that after this experience "one comes to have a very heathy respect for Dichloramine-T as an agent for the prevention of diseases of upper respiratory tract origin." He adds: "The organization numbered 7 in the chart has had the lowest measles and pneumonia rate in Camp Greene and is the only one which has systematically used the nasal spray. Its record is striking, and forms a reasonable basis upon which to recommend that the routine use of nasal spraying with Dichloramine-T be introduced into the camps for the prophylaxis of respiratory diseases."

Virtually the same method of treatment was employed by Major Carey P. McCord, Major Alfred Friedlander and Capt. Robert C. Walker, at Camp Sherman, in the treatment of diphtheria, in an article published in the July 27 issue of the Journal of the American Medical Association, in which they state that in the treatment of these carriers they inaugurated the use of Chlorazene. They employed "an aqueous solution of 0.25 per cent strength, administered as a gargle three or four times daily. In certain cases the application was made by throat specialists to insure the reaching of remote points in the nasopharynx. The gargling was followed with an oily spray of Dichloramine-T of 2 per cent strength. It may not be maintained that the Chloramin action is exclusively responsible for the appreciable reduction of days in hospital of carriers. This is in part due to the Chlorazene-Dichloramine-T treatment and in part to the general painstaking systematizing of the entire care of such patients. Through the use of these several described procedures, it has been possible to return the carriers to duty after an average of twenty-three days in hospital. During the month of May our systematizing of treatment made it possible to discharge all diphtheria patients (sixteen in number) after fifteen days in hospital, and all carriers (twenty-nine in number) after sixteen days in hospital."

The combined use of aqueous Chlorazene solution and the oil solution of Dichloramine-T promises to be of utmost value, not only in preventing diphtheria and meningitis, but also as a prophylactic in pneumonia, measles, streptococcic sore throat and the other diseases originating in the nasopharyngeal tract.

Yeast in the Treatment of Furunculosis.

Hawk and collaborators, in an article entitled "The Use of Bakers' Yeast in Diseases of the Skin and of the Gastro-Intestinal Tract" (Journal A. M. A., Vol. LXIX, No. 15, October 13, 1917), publish the re-

sult of their treatment of furunculosis and other skin conditions with compressed yeast (Fleischmann's). The use of fresh bakers' yeast brought about an improvement or cure in sixteen of seventeen cases of furunculosis, as well as in a case of folliculitis, and in other skin conditions. The cases were followed up weeks to months, after cessation of treatment, without recurrence of furunculosis. One of the cases had previously been treated with vaccines. Fleischmann's Compressed Yeast may be taken in water, beef tea, or orange juice, and there is no reason why it could not be administered spread on bread. The doses usually administered were one-half to one cake three times daily. Some of these patients had been suffering with boils for a long period of time. Usually the cases were cured or boils considerably improved within two weeks after the administration of the first dose. Sometimes, because of gas formation in the gastro-intestinal tract, it was necessary to kill the yeast cells just before administration by immersing the cake for a few minutes in boiling water.

Hawk concludes that "bakers' yeast was found to be a useful remedy in the treatment of furunculosis, acne vulgaris, acne rosacea, constipation, and in certain other cutaneous and gastro-intestinal conditions."

The Illegitimate Baby's Rights.

The rights of illegitimate children and the State's responsibility for seeing that every child, no matter what his parentage, has the nurture, protection, and education essential to his usefulness as a citizen are for the first time given complete national recognition in the Norwegian laws concerning illegitimate children, according to a report issued by the Children's Bureau of the U. S. Department of Labor.

These laws make the State instead of the mother responsible for establishing paternity. The State holds both parents equally and continuously responsible for the illegitimate child—"The child shall be entitled to bringing up — maintenance, training, and education — from both its father and its mother." The report contains a translation of the several Norwegian laws, with amendments, on illegitimate children and their care. A history of the efforts through which the legislation was secured is given in the introduction.

The attitude which looks upon illegitimacy as a child-welfare problem that must be solved for the sake of the child and of the State is exemplified by this Norwegian legislation. In connection with its studies of the bearing of the war upon child welfare the Children's Bureau examined the evidence obtainable but could not find that it justified the statements that have been circulated of widespread increase in illegitimacy since the war. The Bureau believes, however, that the needs of the illegitimate child must be considered in the Children's Year campaign "to save 100,000 children's lives during the second year of the war and to get a square deal for children." In the Children's Year Working Program attention is called to the necessity of providing opportunity for normal development to the child of unmarried parents.

Dependability of Tablets.

There is no doubt about the convenience of tablets, but the accuracy of the dosage content is not always to be depended on. In 1914 Kebler reported the results of a far-reaching investigation of tablet compounding in which he pointed out that tablets on the market were not as uniform or accurate as was generally believed. During the past year the Connecticut Agricultural Experiment Station undertook the examination of tablets—proprietary and nonproprietary—taken from the stock of dispensing physicians. The variations found in weights of the tablets were strikingly similar to those reported by Kebler.

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(1938)

Little Children Deprived of Milk.

That babies and little children are directly affected by the decreased sales of milk reported by dealers in American cities is illustrated by findings for Baltimore made public today by the Children's Bureau of the U. S. Department of Labor.

Of 756 Baltimore children between two and seven years of age, only 29 per cent are now having fresh milk to drink, as against 60 per cent a year ago. And only twenty, or less than 3 per cent of the children studied, are having as much as three cups a day. With the babies under two the Children's Bureau says the situation is a little less serious. Apparently their needs are more generally understood than the needs of the child over two.

The number of families in this group who are buying no fresh milk at all has risen from thirty-seven a year ago to 107, or 29 per cent of those from whom information was secured, and these 107 families include one-fourth of all the children under seven. At the same time, the total daily purchase of canned milk by the families studied has increased from 25.5 cans to 84 cans.

Most serious, according to the Children's Bureau, is the general substitution in the children's diet of tea and coffee. Of the 575 children who are not drinking milk, 64 per cent have definitely substituted tea and coffee, and 24 per cent are "sharing the family diet" which may or may not include tea or coffee, or milk in other foods.

While the group of families studied is small, the Bureau offers the findings as fairly representative since the information was secured and transmitted to the Children's Bureau by school nurses of the Baltimore Department of Health and by nurses of the Instructive Visiting Nurse Association and the Babies' Milk Fund of Baltimore from all families they visited during a certain short period, provided (1) there were at least two children under seven years of age; (2) the family had been in Baltimore at least a year; (3) no tubercular patient was living in the family.

The Punton Sanitarium

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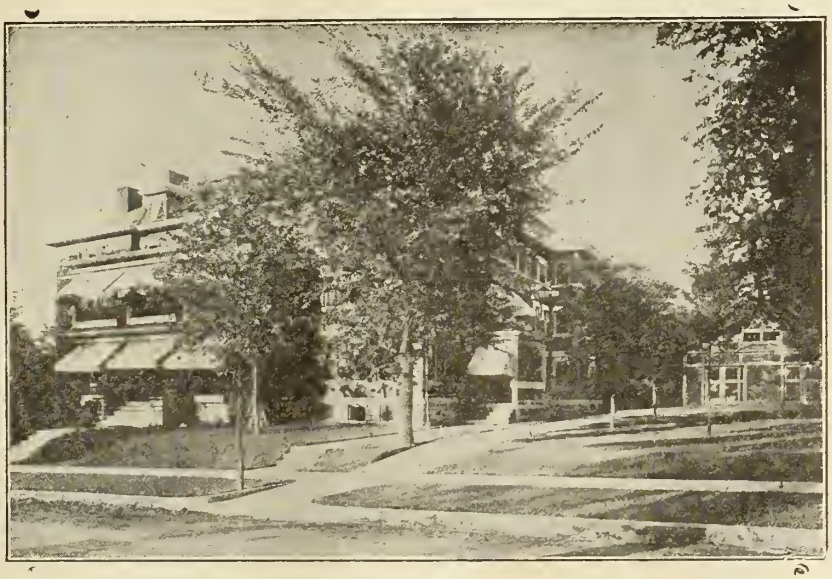

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Various incomes are reported but the changes in the amount of milk purchased are not unlike in the different earnings groups. Some mothers seem to realize that milk must be provided for their children at whatever sacrifice; others who can better afford to buy milk do not understand its importance and let their children go without it. The foreign born mothers, although their incomes are slightly lower than the incomes of the native white mothers, have more generally than any other group continued to buy milk. Almost half of the foreign born mothers have either continued the amount purchased last year or increased it, and only one in ten of the foreign mothers (as against one in three of the other mothers) are now buying no milk at all.

The Children's Bureau states: "Taking a pint and a half of fresh milk as the desirable daily allowance for the average child, those 756 children were having last year on an average daily only 40 per cent of what they should have had; this year their daily average has dwindled to 14.4 per cent of this allowance.

"The work of Children's Year should emphasize in every community the importance of fresh milk in the diet of young children. Without proper nourishment children can not keep well and free from physical defects, and a campaign of education on the feeding of children is an essential part of the saving of 100,000 lives during the second year of the war."

Conversion of Liberty Bonds.

Liberty Bonds of the first issue, Liberty Bonds of the second issue, and Liberty Bonds obtained by converting bonds of the first issue into bonds of the second issue can be converted into bonds of the third issue during the six months' period beginning May 9 and ending November 9, 1918.

Delivery of the bonds issued in conversion can not be made prior to July 1, but bonds presented for conversion on or before that date will be retained by the Treasury and a nonnegotiable receipt issued therefor. Interest will be adjusted

in each case between the Government and the bondholder.

After November 9, 1918, no further rights of conversion will attach to the 4 per cent bonds, either the original bonds of the second loan or those obtained by conversion of bonds of the first loan. Bonds of the first issue, however, will still have the privilege of conversion into any bonds issued, at a higher rate of interest than 3½ per cent, before the termination of the war. All of the 4¼ per cent bonds are nonconvertible.

Bonds for conversion may be surrendered at any Federal Reserve Bank or at the Treasury Department. Registered bonds must be assigned to the Secretary of the Treasury, but such assignment need not be witnessed.

On conversion of registered bonds, registered bonds only will be delivered, neither change of ownership nor change into coupon bonds being permitted.

Coupon bonds, however, may be converted into registered bonds upon request. Coupon bonds must have the May 15, or June 15, 1918, coupons and all subsequent coupons attached. Coupon bonds issued from conversion will have only four interest coupons attached, and later must be exchanged for new bonds with the full number of coupons attached.

All bonds issued upon conversion into 4½ per cent bonds will be dated May 9. The bonds secured upon conversion of bonds of the first loan and bonds obtained by conversion of bonds of the first loan into 4 per cent bonds must carry interest from June 15. Bonds issued upon conversion of 4 per cent bonds of the second issue will carry interest from May 15.

Furnishing a Substitute.

Bessie had a new dime to invest in ice cream soda.

"Why don't you give your dime to missions?" said the minister who was calling.

"I thought about that," said Bessie, "but I think I'll buy the ice cream and let the druggist give it to the missions."—Christian Herald.

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(1943)

Important Information

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, SEPTEMBER, 1918 No. 9

The Enlarging Scope of Neurological Surgery.

ERNEST SACHS, M.D., F.A.C.S., St. Louis, Missouri.

Associate Professor of Surgery, Washington University Medical School.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

In 1885 Victor Horsley removed the first brain tumor successfully and in 1887 the first spinal tumor. This was almost eighty years after McDowell did his first ovariotomy.

Neurological surgery may be said to have started with those two successful cases, but the subject has but slowly gained the recognition it deserves. This may be accounted for in several ways. First of all, the profession generally does not realize that there are quite a number of neurological conditions which can be effectively trained by surgical measures. Secondly, the lack of neurological training and consequently the lack of interest in these conditions.

Neurological surgery to most medical men means operations for brain tumor and that, as a rule, they think, spells disaster. It is true that the results of brain tumor operations are not as satisfactory as they will be when we get these cases earlier, that is, when in the operable stage, but the results are already better than they were five years ago.

This feeling about the seriousness and danger of operations for brain tumor has been applied indiscriminately to every cranial operation, which is most unfortunate, for it keeps physicians from advising operation to patients who might readily be relieved and at comparatively small risk. Some years ago I reviewed our cases and found that in a consecutive series of sixty-four cranial operations, we had had six deaths, a mortality of 9.3 per cent. These figures need to be improved but certainly are by no means discouraging. Ninety-six cases with brain tumors, 20 per cent mortality.

What types of conditions, then, lend themselves to operation and may be cured or relieved by surgical intervention?

Quite a large group even after all cases unsuitable for operation have been eliminated is made up of epilepsies. I am drawing the line sharper and sharper each year as to which epilepsies should be operated. Unless the convulsions present a definite focal character, I leave them alone, but it is well to remember that the patient whose general convulsion is initiated by a definite sensory aura, a sensation of smell, taste, vision, or hearing, has just as much of a focal or Jacksonian convulsion as the patient whose thumb twitches characteristically for half an hour before his general convulsion begins. In other words, many epilepsies are called general that on careful study really prove to be focal. Some of these cases have traumatic cysts following old injuries; not a few have a more diffuse process that I usually speak of as a subarachnoid cyst; some have the remains of an old chronic meningitis; an occasional one (two in my experience) have a congenital nævus. One of these had been having twenty to thirty

Jacksonian attacks a day and since the operation some three years ago has had none.

What are the results in these cases? Of twenty-three cases which occurred in the course of several years, we lost none.

The next question is, are they all relieved of their symptoms? No, not all, but a good many have no more convulsions at all. What sort of an operative procedure is required to relieve these conditions? Sometimes a mere evacuation of the cyst suffices; at other times the entire cortex which is diseased must be excised, but unless absolutely necessary, I do not resort to this latter procedure, as it means, if the excised portion is in the motor area, that the patient will have a paralyzed extremity. I have done such an excision only three or four times. Patients, however, are quite willing to have a paralyzed extremity rather than continue with their convulsions. Then, too, a patient after a cortical excision which has produced paralysis may regain considerable power in a few weeks so that he can use his extremity to some extent.

There is another group which is becoming more interesting as prospect of relief becomes more promising, namely, hydrocephalus.

The increase of our knowledge of this condition is an admirable example of how this field is growing. Until a very few years ago all cases of hydrocephalus were considered alike; now we are able to differentiate three types — the obstructive hydrocephalus, the secretory hydrocephalus, that is one in which there is an excessive secretion of cerebrospinal fluid, and a third, the absorptive type, in which the cerebrospinal fluid is not taken up in the circulation as rapidly as normally and consequently might be said to stagnate.

This differentiation is accomplished by the injection of a specially prepared phenolsulpho-phthalein into the ventricle, and normally it should appear in thirty seconds in the spinal fluid upon lumbar puncture. If it is delayed beyond a certain time, arbitrarily set at twenty minutes, there is an obstruction between the ventricle and spinal meninges and we are dealing with an obstructive hydrocephalus. On the other hand, if the dye appears promptly in the spinal fluid and also promptly in the urine, we have the secretory type, while if the phenol-phthalein appears promptly in the spinal canal, but slowly in the urine, the defect is one of absorption. Once having determined what kind of hydrocephalus we are dealing with, the treatment may be more intelligently undertaken.

In the first type, the obstruction can only occur at the foramen of Magendie and foramina of Luscka in the roof of the fourth ventricle or at the aqueduct of Sylvius. The making of a new foramen of Magendie is quite simple by an operation that I shall illustrate to you a little later. The relief of a number of cases indicates that this is a promising procedure. Obstruction of the aqueduct of Sylvius is a more difficult problem to deal with, but not insurmountable. This past year I have had a case of a tumor in this region in a child of eighteen months, which we removed, and this indicated that the procedure is possible. This child was operated some eight months ago and when we removed the tumor, cerebrospinal fluid escaped from the obstructed aqueduct of Sylvius.

The operative procedure used in these cases also creates a new area from which cerebrospinal fluid may be absorbed and therefore may be used in those cases of hydrocephalus in which absorption has been defective. This operation, it seems to me, is a more logical one than the many that have been devised in which channels for absorption of cerebrospinal fluid were created by foreign bodies, tubes, strands of catgut, linen thread, rubber tubes, etc., for the objection to all of these is that an irritative inflammation is set up which soon closes the newly created pathway.

The third type should be treated, I believe, as hypersecretion of other glands, notably the thyroid is treated, namely by partial excision of the choroid gland. That seems wild and impossible but in a hydro-

cephalic the ventricle is reached very easily and extirpation of the plexus would offer no great difficulty. Though I have not as yet had a suitable case on which to carry out this procedure, I have several times been in the lateral ventricle and know that it can be done, and furthermore, that patients, particularly hydrocephalics, stand opening of the ventricle well.

Occasionally, among the vast army of syphilitics we see cases with choked disc and rapidly failing vision. These do wonderfully well with a decompression promptly done; in fact, patients often respond to antisyphilitic measures better after a decompression has been done than before. This I believe may be due to the fact that the increased intracranial pressure interferes with the absorption of specific drugs but after the pressure has been relieved this goes on more readily.

A choked disc should always be a clear indication for operation, and a delay while prolonged specific treatment is tried often ends disastrously. Let me take this opportunity to emphasize that the fewest cases giving symptoms of intracranial pressure are due to syphilis. A cerebral gumma is very rare and *it* is a tumor and cannot be readily, if at all, removed by antisyphilitic treatment. It must be removed by operation.

Perhaps the most gratifying cases in the whole field of neurological surgery are the trigeminal neuralgias. If the second or third branch of the fifth nerve is involved, or both of these, I think it always well and wise to try deep injections of alcohol according to the method popularized by Patrick. The first branch of the fifth nerve I think should not be injected with alcohol on account of the danger of injuring the optic nerve, for to inject it the alcohol has to be put into the orbit. Those neuralgias that recur after alcohol injections or which have involvement of all three branches of the fifth nerve should be operated upon. I do not believe in the various peripheral operations, however, as they give temporary, often no relief at all. After having exhausted the alcohol injections the only operation is that on the Gasserian ganglion. This operation is generally considered very dangerous, very difficult, and having a high mortality. It is unquestionably a serious procedure, but when done carefully and deliberately, not dangerous. Our own series is small, some twenty-odd cases, but thus far we have not lost a patient, so that we feel justified in advising the operation. Does it always cure? Yes, always if properly done, and whenever there is a recurrence the operation has been imperfectly done; that is, all the fibers of the ganglion have not been removed.

A very large series of cases is that of skull fractures, and here I get to a subject with which many of you are very familiar and about which, perhaps, you have very strong views. It is a subject that has assumed enormous importance in the past years, since, in addition to the many skull fractures that occur in civil life, gunshot wounds of the head have become a grave problem in the case of our soldiers. Ten per cent of all wounds at the front are head wounds, so that with the huge number of men engaged you can appreciate what a terrific problem we are face to face with. The injuries sustained in war differ in one respect from those occurring in civil life, in that the former are almost all compound fractures so that the danger of infection is present. Infections of the brain and meninges are still problems that have not been satisfactorily solved and it is devoutly to be hoped that some very definite advance may be made along these lines before many of our boys get into the fighting. Certain points, however, will do much to give better results in these compound fractures. The literature based on war wounds draws attention constantly to the difference between a contaminated and an infected wound; that is, a wound that has dirt in it at first is not infected and if it is radically cleaned out and sewed up, many will heal by primary union. I am convinced that this is the secret of treating brain wounds. Excise all the traumatized brain tissue and sew

up the wound tightly; don't drain. It is the draining of brain wounds that leads to trouble. If there is a large defect in the scalp as well, a skin flap should be swung over from another part of the scalp in order to cover the defect in the skull. In regard to the treatment of simple skull fractures our views are more settled. With improvement in technique and a better understanding of the mechanics involved in the production of fractures as well as appreciation of the fact that the most serious feature of a cranial fracture is the injury to the intracranial contents, the results have been steadily improving.

Men differ as to their operative indications, but not as much as formerly. A carefully done decompression in which the brain is not traumatized and in which intracranial tension is reduced by removing cerebrospinal fluid is often the only operative procedure that is required.

In every children's clinic a considerable number of patients are mental deficients, many of them also having various types of spasticities. One or two men have claimed that many of these cases have choked disc and increased pressure in their spinal fluid, and that a decompression operation cures or greatly improves them. I have looked for a long time for such cases in the large pediatric clinic that I have had at my disposal, but thus far have never seen one. Therefore, I hesitate to recommend this procedure. Occasionally, however, these cases have localized collections of fluid due to some birth injury, and if this is removed they are helped surprisingly.

Brain tumors constitute the most important and most interesting, though not the largest group of cases. It is true, as I said in the beginning of my remarks, that results are not as good as in other cranial cases, but they are steadily improving. Why this difference in results, and can we correct this difficulty? The results can certainly be improved, but to accomplish that we need the help of the general practitioner. They are the men who see these cases first and it is up to them to see that they get prompt relief. Now why does the general practitioner delay? For three reasons: (1) Because his books all tell him that a case of brain tumor has three cardinal symptoms—headache, vomiting, and progressive loss of vision. (2) He was taught in his school days that brain tumors are very rare conditions and that headaches of intracranial origin are usually due to syphilis. (3) Because he thinks an operation on the brain is so dangerous that as a conscientious physician he is afraid to recommend it.

First, as to these three cardinal symptoms. Many brain tumors reach an advanced stage before they show any of these symptoms. In certain patients they never are prominent; that is particularly true in children, and when the tumor is located in the anterior fossa or pituitary region. Frequently the only one of these three general symptoms that is complained of is headache. Now we all know that countless other conditions cause headache. What I would urge upon you is not to put brain tumor as a possible cause of this symptom so far down on your list that by the time you come to consider that as an etiological factor, weeks or months of precious time have been lost. Then, too, I trust the time is not far distant when practitioners generally will use the ophthalmoscope with as great ease as they now use the stethoscope and the microscope, for before, *often long before* a patient notices impairment in vision, the ophthalmoscope reveals a beginning choked disc. Whenever we see a patient with some progressing nervous disorder we ought to look at the case early from the neuro-surgical angle to determine whether or not we are dealing with a tumor.

Secondly, if such a case with a progressive disorder has a negative Wassermann, it is as wrong to give that patient antisyphilitic treatment as it is to give the patient with a ruptured appendix and spreading peritonitis a hypodermic of morphine to relieve his symptoms. *There is no curative value in such a procedure.* If, for some reason in spite of the negative

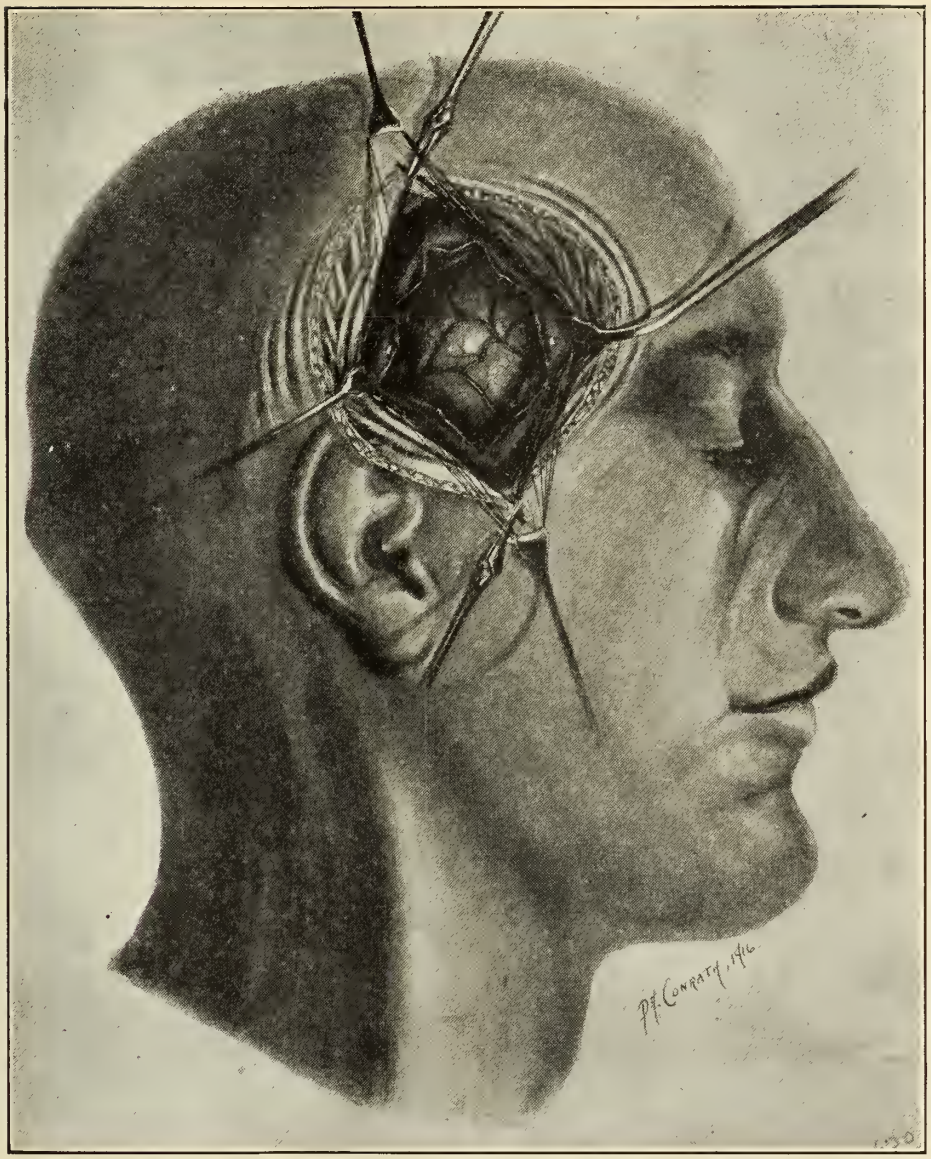


FIG. IV—This shows the method of placing the first layer of sutures in the temporal muscle prior to opening the dura. Sutures are retracted while the dura is incised; this is a very useful procedure when there is marked pressure, as the brain can be rapidly covered by a protective layer of muscle before it ruptures. Silk sutures are used throughout. Whenever possible, cerebro spinal fluid should be removed, however, before the dura is opened, so that the brain will not bulge. Note the numerous radial incisions in the dura in order to completely relieve the tension. The opening in the dura should be so large that the brain pulsates freely. In every decompression the dura must be left open.

Wassermann, you try specific treatment, do it intensively, and if marked improvement is not noticeable in two or at most three weeks, you may be quite certain that your patient's trouble is not due to syphilis.

Thirdly, cranial operations should not and do not have the high mortality they used to have. The factors that have brought about this change are:

1. The development of a technique for operations on the nervous system that is different than that used elsewhere in the body and which is designed to deal with these special tissues.

2. A trained corps of assistants who are familiar not only with this special surgical

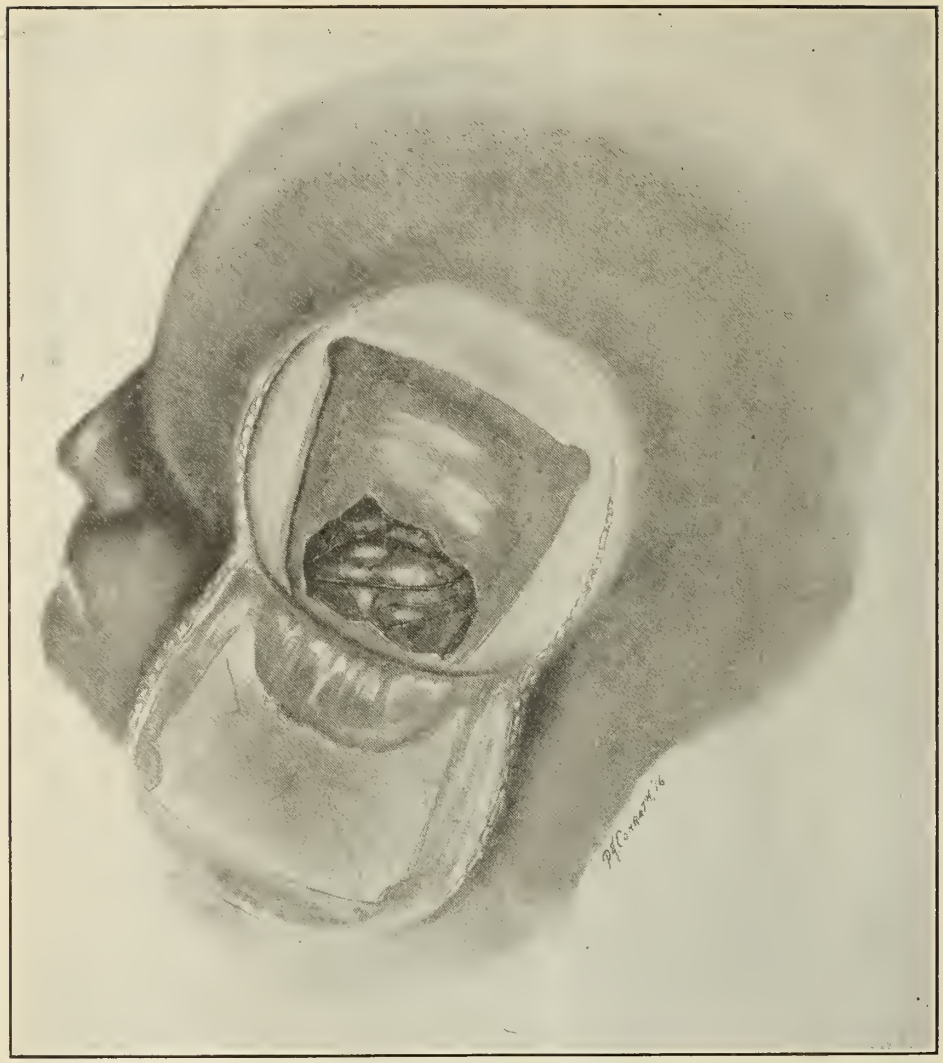


FIG. VII—This shows the method of combining a subtemporal decompression with an osteoplastic flap. Note the way the bone is rongeured away so that only muscle lies over the brain which is unprotected by the dura.

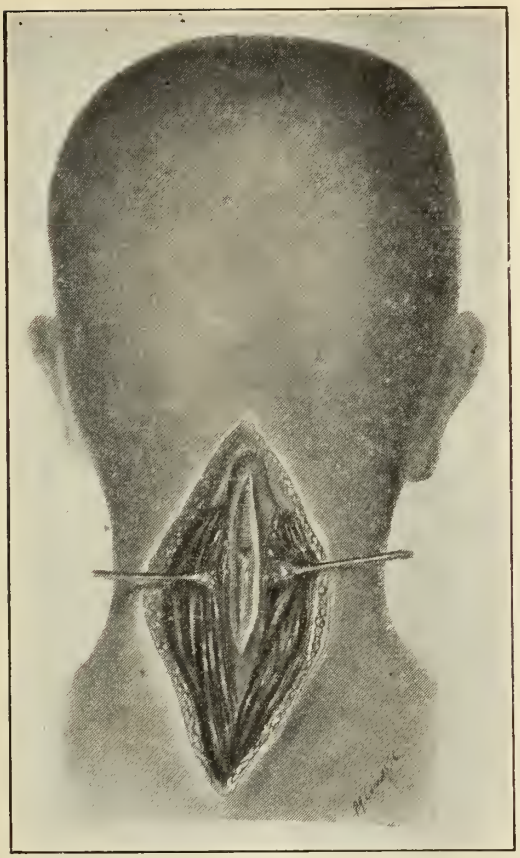
technique but who are well grounded in the anatomy and physiology of the nervous system.

3. Multiple operative procedures with the idea of first relieving increased intracranial tension before attempting a tumor extirpation.

4. Last, but very important indeed, an expert anesthetist who gives an even and much lighter anesthesia than is ordinarily used in abdominal surgery.

Thus far I have considered but a small portion of the nervous system, for the spinal cord and peripheral nerves offer numerous problems. There are four groups of conditions that develop in the spinal cord that are surgical: First, fractures and dislocation of the vertebral column; second, tumors; third, the localized chronic meningitides; fourth, spastic conditions of unknown origin.

The views about traumatic lesions of the cord vary a good deal. The usual advice is not to operate if the cord has been completely cut across, but if there is compression, usually to explore. All these authorities neglect to tell us, however, how to distinguish a complete anatomical division of the cord from one which is compressed but not cut across, and for a very



FIX. IX—The method of exposing the basal cisterna and the floor of the fourth ventricle in order to relieve an obstructed foramen of Magendie. This can be very readily extended into a cerebellar exposure of the entire posterior fossa.

good reason. In the first twenty-four hours there is *no* way of distinguishing whether a complete paraplegia is due to a blocking of the nerve paths or an actual division of the cord. The blocking of the nerve paths is due to hemorrhage or œdema into the cord; if this is not relieved promptly, that is within forty-eight hours at the longest, degenerative changes set in; therefore, to help them they must be operated early and I believe all these cases should be explored in the first twenty-four hours, even though some cases will be operated upon that have had their cords completely severed.

Every spastic paraplegia whose Wassermann on the spinal fluid and cell count are negative, on whom one can demonstrate any evidence of a focal lesion, should be explored, and unless he has been explored, he has not had his fair chance at recovery. Both tumors and localized or so-called serous meningitides may be cleared up by operation.

In certain cases, spasticity may be relieved by cutting some of the posterior spinal roots.

Spinal operations are perhaps not dreaded quite as much as cranial operations, but they also are supposed by many to have a prohibitive mortality. Our experience does not justify that idea. In thirty cases we lost three and one of these died of angina pectoris three weeks after operation.

Of the operations on the peripheral nerves, little need be said except that with an improved technique and careful attention to the minute details nerve sutures are yielding better results than heretofore. Probably no single group of cases is having more light shed upon them in the war than these.

(At this point a number of slides were shown by which the author emphasizes some of the factors that have tended to increase the scope of this work.)

In conclusion, I should like to point out that with better results in these cases the general practitioner will become more interested in the neurological aspect of his cases and come to realize that the diagnosis of neurological conditions is not an insurmountable difficulty. In addition, he will have a group of cases which he formerly classes as hopeless to whom he now may hold out the prospect of relief.

Pulmonary Tuberculosis: Its Nervous Manifestations.

C. S. KENNEY, M.D., Norton, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

There would be no excuse to take up your time nor further add to the volumes that have been written on the subjcet of tuberculosis were it not that I have the conviction that the nervous and mental phase of this disease has been sadly

neglected. Being a chronic disease of the masses, many have been the contributions since the days of Hippocrates; but, until quite recently, little attention has been paid to the explanation of the mental, psychic, and nervous manifestations of this malady. It is my intention, therefore, to set forth, briefly, some of the observations that have been made by careful observers, especially Eppinger, Hess, Gaskell, Cannon, Higier, Schœffer, Pottenger, Lapham, etc. Much has been written about tuberculosis and syphilis, two prevalent chronic diseases, one called the "great white" and the other the "great red" plague. All of us have been admonished to carefully consider each of these diseases before making a diagnosis of any obscure chronic diseased condition. We are now, more than ever before, beginning to appreciate that each has a great bearing on the physical, moral, mental, and nervous manifestations of its victim. Heretofore, the psychic, mental, and nervous manifestations observed in a tuberculosis sufferer was passed by with but little comment. Hence, no attempt was made to explain them. I believe if these conditions were better understood and more consideration given the sufferers, much of the misunderstanding in the homes of the victims would be eliminated. If the affected person and his friends could fully realize that it is a chronic disease with local and systemic manifestations and that one, so infected, would have these marked disturbances, we will have gone a long way toward solving the problem of caring for a tuberculous individual. Unfortunately, however, the irritability, malaise, weakness, etc., in tuberculosis is not nearly so well understood as it is in syphilis, typhoid fever, or pneumonia.

All of us are more or less familiar with the general nervous system; hence, any minute discussion of its embryology, histology, anatomy, and physiology would be superfluous. We are, in fact, interested in this discussion, only in that portion which controls the general organs of the body. For lack of a better term it is called the "vegetative nervous system." It furnishes impulses for carrying on those particular bodily functions that are necessary for the preservation of life. It acts, as you are aware, without any inter-position of the will. By studying the effects of tuberculosis on this system, one can better understand the various manifestations of this chronic toxemia.

The vegetative nervous system springs from the central nervous system. For this discussion, it may be divided into the greater vagus and sympathetic subdivisions. The greater vagus comes from the cranial-bulbar and sacral divisions of the cord, while the sympathetic is given off from the thoracico-lumbar divisions. All the body organs, with the possible exceptions of the sweat glands, the pilo-motor muscles, and the vascular muscles of the viscera, are innervated by both. The actions of these two divisions are antagonistic; hence, stimulation of one depresses the other. But, when the sum total of stimulation of one equals the sum total stimulation of the other, we have a condition of health which is maintained until one is over-stimulated. Then, the equilibrium is disturbed and a dysfunction results.

To a certain extent, these divisions of the vegetative systems are regulated by the secretions of the internal glands: the vagus by the pancreatic secretions; the sympathetic by the adrenal, thyroid, and other ductless gland secretions. If either is over-secreted, a dysfunction results. It is very interesting to note that toxemia and depressive emotional states, such as fear, anxiety, discouragement, worry, and disappointment, have very similar symptom complexes. This is very easy to recognize in tuberculosis, because it is a disease which manifests so many periods of slight activity, accompanied by a low or moderate degree of toxemia, which disappears after a few days duration; and because it is likewise accompanied by so many of the depressive emotional states, which come and go as the causes which produce them.

The symptoms of toxemia and depressive emotional states are: headache, malaise, nervous irritability, insomnia, lack of endurance, loss of appetite, coated tongue, inhibition of gastric and intestinal secretions and motility, constipation, fever, pallor, and, at times, sweating. All of these symptoms are not always present; but they are, in a sufficient number of instances, to indicate they are the result of a central sympathetic stimulation.

For years we have endeavored to standardize the diagnosis and treatment of tuberculosis, but have only partially succeeded. An early diagnosis is important, so that proper treatment may be established in time to give the patient the best chance to recover. A number of very definite symptoms stand out prominently. They are: malaise, a finicky appetite, a tired feeling, especially early in the morning after a good night's sleep; nervousness, irritability, a delicate hacking cough, etc.

It is certainly sensible to class tuberculosis as *infectious*. We can then understand readily that it is not hereditary, and should take the stand that without infection there can and will be no disease; or, in other words, no infection, no clinical manifestations, hence no disease. Formerly those who were weak and run down were said to have a *predisposition* to tuberculosis. Now we are beginning to understand that there is really not necessarily a *predisposition* to tuberculosis any more than there is to typhoid fever, pneumonia, or other diseases. For years we have used the term, "pre-tuberculous stage," which, like Cæsar's ghost, rises up to plague us. We are now convinced that no "pre-tuberculous stage" exists, but instead the symptoms of malaise, weakness, loss of weight, nervousness, etc., at that period are really manifestations of tuberculosis. We recognize and class this stage today as incipient tuberculosis. Thus, we can dismiss from our minds heredity, predisposition, and the pre-tuberculous stage.

We are able to explain satisfactorily the various manifestations of this disease by a better understanding of the effect of the specific toxins on the vegetative nervous system.

The following symptoms will lead to a positive diagnosis of tuberculosis: A finicky appetite, increase of pulse rate, increase of temperature, changes in blood, hoarseness, tickling in the larynx, circulatory disturbances, chest and shoulder pains, rigidity of muscles, flushing of the face, apparent anemia, frequent and protracted colds, blood spitting, pleurisy, and sputum. These, plus a lagging of the chest on one side, with rigidity or increased muscle tonus over one area of the chest, increased vocal fremitus, localized cog wheel, and localized prolonged high-pitched expiratory sound on one side, point to and compel us to make a tentative diagnosis of tuberculosis.

We have previously stated that when stimulation of both branches of the vegetative system is equal, there is no dysfunction. Tuberculosis is, if anything, a chronic disease. It has one or more foci that cause local irritation of nerve filaments. Later these foci give off toxins which produce the symptoms that have been enumerated. In other words, for years all cells of the body are bombarded by toxic materials which produce a chain of well known symptoms. It is no wonder then that the poor victim is undermined, his strength lessened, and he has a nervous and a mental instability, dyspepsia, with chest and shoulder pains, a hacking cough, and other symptoms. He may look well, but he is a substandard man, unable to assume all the grave responsibilities of life. He is misunderstood. He is self-centered, selfish, and perhaps contrary, showing a peculiar negativism about men and affairs. His strength and ability to toil are over-rated and he is accused of being lazy, finicky, cranky, a neurasthenic, and a *grouch*. The toxins often stimulate the mental faculties, and many are alert in arts, sciences, and literature. They are visionary, self-opinioned, and prone to build air castles; but their strength is not equal to the tasks they assume and they break under the strain, becoming hopeless

wrecks, if nothing is done to stay the process.

Stimulation of the sympathetic system by the toxins produce hypo-secretion, hypo-motility, a fast pulse, etc. If, however, the peripheral stimulation of the greater vagus is in the ascendency, we may expect hyper-secretion, hyper-motility, and a moist clean tongue. These cases are called the vagotonic type. If the gastric filaments are greatly stimulated, we have a condition of hyper-chlorhydria, often with pyloric spasm, simulating gastric ulcer. In fact, many patients who gave histories of hyper-chlorhydria and gastric ulcer previously, have been admitted to the State Sanatorium at Norton with active tuberculosis. In every instance, they were of the vagotonic type with a slow pulse, a normal or nearly normal temperature, and good digestion. This type has a favorable prognosis. It is also interesting to note that the vagotonic type also show evidence of irritation of the appendix. In one case observed, a number of attacks of pain that appeared to be an involvement of the appendix were noted. It might be well for us to consider the possibility of tuberculosis in cases of recurrent or chronic appendicitis.

For years we have recognized the fact that a typhoid patient having a slow pulse and a low temperature had a better chance to recover. It is also almost an axiom in tuberculosis that one who has a good heart and a good digestion and who faithfully, hopefully, and willingly submits to treatment, has a better chance for recovery. In as much as the vagus stimulation is in the ascendency, the reason is quite evident. We find in tuberculosis that the functions of all organs are unstable. The pulse, with the patient at rest, is usually slow, but on exercise, during periods of toxemia or depression, becomes rapid. The appetite improves by rest, but it is disturbed by toxins and depressive emotions. In other words, when the toxemias are diminished, conditions improve.

The greater vagus system conserves a healthy tone of the important internal organs. If its stimulation is in the ascendency, it offers the patient increased opportunities for recovery. On the other hand, if the vagus tone is lowered and the stimulation of the sympathetic becomes prominent, the chances grow less, because there is a lessened secretion and motility of the digestive organs, a rapid pulse, irritability, nervousness, etc.

Taking the classification, from Pottenger's Clinical Tuberculosis, we will now consider the symptoms of tuberculosis under three heads:

Symptoms Due to Toxemia	Symptoms Due to Reflex Cause	Symptoms Due to Tubecculous Process per se
Malaise	Hoarseness	Frequent and protracted colds
Feeling of being run-down	Tickling in larynx	Spitting of blood
Finicky appetite	Cough	Pleurisy
Lack of endurance	Digestive disturbances	Sputum
Loss of strength	Loss of weight	Temperature
Nervous instability	Circulatory disturbances	
Digestive disturbances	Chest and shoulder pains	
Loss of weight	Flushing of face	
Increased pulse rate	Apparent anemia	
Night sweats		
Temperature		
Blood changes		

"It will be noticed that this first group of symptoms is expressive of central nerve stimulation; that its action is that of a general inhibition of function; that the symptoms are expressed widely through the body and when taken together form a symptom-complex which is particularly expressive of a general nervous discharge through the sympathetic nervous system." Tuberculosis, however, being so chronic in nature, has its periods of activity and quiescence; hence, these symptoms are not present at all times.

The importance of these symptoms cannot be over-estimated; of especial importance is malaise, the tired feeling, espe-

cially in the morning after a good night's rest, the nervous instability, dyspepsia, and the neurasthenic tendencies, which are often diagnosed as neurasthenic. We wonder if neurasthenia should not be called a condition and not a disease; if it does not have a physical basis, often tuberculosis, and if by rest, the underlying cause is removed, the symptoms disappear. We also wonder how many lean, sallow, cranky, flat-chested dyspeptics are not really suffering from the toxemias of tuberculosis, instead of from some disturbances of the digestive apparatus *per se.*

The symptoms, due to reflex causes, result from a stimulation of the greater vagus at the periphery. This explains the chest pains, flushing of the face, hoarseness, tickling in the throat, and a slight hacking cough, especially that delicate little hack that many euberculous patients employ in clearing the throat. We should, in all cases, make a thorough physical examination of all chests before making the diagnosis of throat trouble. I believe, if we do this, many undiagnosed cases of tuberculosis will be discovered and a far less number of tonsils will be sacrificed in a vain effort to relieve a cough. Of course there are many symptoms due to diseased tonsils, but I fear snap judgment is too often taken. The tonsils are enucleated often to relieve symptoms in the throat but the patient does not improve. The symptoms become more pronounced and, in time, a complete breakdown, which every one recognizes as tuberculosis, results. In the institution we have treated several who came with a similar history, having been treated for various ailments which proved later to be tuberculosis.

Chest pains and increased muscle tone or rigidity of chest muscles are reflex symptoms that point to an infection beneath the chest walls. We have for years expected to find an infection in or adjacent to the appendix with pain and rigidity over McBurney's point. If, then, pain, rigidity or increased tension of the muscles in this region, a rise of temperature and an increased pulse rate, and toxic symptoms of malaise with dyspepsia and nausea point to a diagnosis of appendicitis, why does not the same symptoms indicate an infection of the lungs, when the symptoms are in the chest rather than in the abdomen?

A patient that is slightly ill with a pain in the abdomen receives a careful examination and an attempt is made to diagnose his case properly. Are we as careful when one comes to us with malaise, neurasthenia, dyspepsia, and chest pains, or do we pass it off lightly as a "dyspepsia," "nervousness," "malaria," or a "rundown condition"? The conditions are identical and one may be diagnosed as easily as the other. We are, however, slow in establishing a definite basis for diagnosing tuberculosis. We have a few classical symptoms in appendicitis, gall bladder infection, and typhoid fever, that are well understood. I believe, if we take two or three symptoms from the toxic group, one or two from the reflex, and one or two from the class of tuberculous process *per se,* and add these to two or three definite signs found on physical examinations, we will be in good position to make a diagnosis of pulmonary tuberculosis fairly early.

To me the nervous and mental side of this subject is very interesting, and in conclusion I wish to make an appeal to you to further observe the effects on the progress of each case by this bombardment of the vegetative nervous system by the toxins produced by this chronic, infectious disease.

At the State Sanatorium we made observations relative to the constancy of the symptoms in these three groups and were impressed with their reliability.

100 per cent had malaise.

100 per cent had disturbances of digestion.

96 per cent had sputum.

96 per cent had cough.

96 per cent clearing of the throat.

92 per cent pleurisy.

96 per cent chest pains.

68 per cent spat blood.

Some one has said that at twenty many of us have the disease that will kill us at forty. We can go further than that and say that at ten many of us have the disease from which we will suffer at intervals during our life and finally die of it, unless we take pains to arrest it. I refer to tuberculosis. Many a child has had the slight rheumatic attacks known as growing pains, has then developed chorea or St. Vitus' dance, together with some involvement of the heart, and died at the age of forty or so with heart trouble. Many a child has suffered with an attack of scarlatina, perhaps very mild in the immediate symptoms, developed a complication of the kidneys, and died at forty or thereabout of Bright's disease. Many a child has been infected with tuberculosis; perhaps he grew up puny, with a bright eye, was irritable, and was subject to bronchitis and colds. Maybe he had a tuberculous exacerbation which is called pneumonia, or typhoid. He makes a slow recovery from that but for years he has dyspepsia, and a little hacking cough. Finally he dies from tuberculosis, or as people say, consumption, at forty or thereabout.

In other words, the red strand connects all diseases of the child and adult, and the mitral heart death resulted from the early growing pains by well recognized steps and pathological changes; and the uremic death resulted from the previous "scarlet rash" in the same way.

Now we know that, in the majority of instances, the death from consumption usually results from a long continued series of changes initiated during childhood days.

As Von Behring has said, "Consumption is but the end of the lullaby that was begun at the cradle of the victim."

———R———

Clinical Eponymic Signs.

(Continued from Page 199)

OPPENHEIM'S SIGN—Contraction of the tibialis anticus, extensor hallicus longus, extensor digitorum communis, and sometimes of the peroneal muscles on stroking the median surface of the leg at the posterior margin of the tibia from above downward; seen in spastic conditions of the lower extremities.

OPPOLZER'S SIGN—On palpation the seat of the apex-beat is found to change with the alteration of the patient's posture in cases of serofibrinous pericarditis.

OSLER'S PHENOMENON — The agglutination of the blood-platelets observed in blood immediately after its withdrawal from the body.

PARKINSON'S SIGN—An immobile, mask-like expression in paralysis agitans.

PARROT'S SIGN—Dilatation of the pupil when the skin is pinched; it is noted in meningitis.

PASTIA'S SIGN—Transverse lines, usually two or three, in the fold of the elbow in scarlet fever. They are rose-red at first but later turn dark red or wine-colored. They are visible before the appearance of the rash, remain through the eruptive stage, and continue after desquamation.

PAUL'S SIGN — Feeble apex-beat, with forcible impulse over the body of the heart, in adherent pericardium.

PEREZ' SIGN—A loud friction murmur heard over the sternum when the patient raises his arms, especially the left, over his head and lets them fall again; it is noted in cases of aneurysms of the arch of the aorta and mediastinal tumors.

PFUHL'S SIGN, P.—JAFFE'S SIGN — In subphrenic pyopneumothorax the liquid issues from the exploratory puncture or incision with considerable force during inspiration, while the contrary occurs in true pneumothorax.

PILCZ' SIGN—WESTPHAL-PILCZ' PHENOMENON—Contraction of the pupil, followed by dilatation, after vigorous closing of the lids; caused by tension of the orbicularis muscle.

PINARD'S SIGN—After the sixth month of pregnancy, a sharp pain, upon pressure over the fundus uteri, is frequently a sign of breach presentation.

PINS' SIGN—A sign seen in pericarditis, consisting of disappearance of the symptoms that stimulate pleurisy when the pa-

tient is placed in the knee-chest position.

PIOTROWSKI'S SIGN — Percussion of the tibialis muscle produces dorsal flexion and supination of the foot. When this reflex is excessive it indicates organic disease of the central nervous system.

PITRES' SIGN—(1) "Signe du cordeau." The angle formed by the axis of the sternum and the line represented by a cord dropped from the suprasternal notch to the symphysis pubis indicates the degree of deviation of the sternum in cases of pleuritic effusion. (2) Hyperesthesia of the scrotum and testes in tabes dorsalis.

POOL-SCHLESINGER'S SIGN—A spasm of the extensor muscles of the knee and of the muscles of the calf in tetany.

PORRET'S PHENOMENON — When a continuous current is passed through a living muscular fiber the sarcous substance shows an undulating movement from the positive toward the negative pole.

PORTER'S SYMPTOM — Tracheal tugging. See Oliver's Symptom.

POTAIN'S SIGN—Extension of percussion dullness in dilatation of the aorta from the manubrium to the third costal cartilage on the right-hand side.

POTTENGER'S SIGN—(1) Intercostal muscle rigidity on palpation in pulmonary and pleural inflammatory conditions. (2) Different degrees of resistance on light touch palpation, noted (*a*) over solid organs when compared with hollow organs; (*b*) over foci of disease in the lungs and pleura when compared with that over normal organs.

PREVOST'S SIGN—Conjugate deviation of the eyes and head, which look away from the palsied extremities and toward the affected hemisphere. It is noted in cerebral hemorrhage.

PSEUDO-GRAEF'S SIGN—Slow descent of the upper lid on looking down, and quick ascent on looking up; seen in conditions other than exophthalmic goiter.

PUTNAM-DANA'S SYMPTOM-COMPLEX — Combined sclerosis of the lateral and posterior columns of the spinal cord.

QUINCKE'S SIGN—A blanching of the finger nails at each diastole of the heart; seen in aortic insufficiency.

QUINQUAUD'S SIGN — Trembling of the patient's fingers, felt when his fingers, spread apart, are placed vertically in the palm of the examiner's hand; said to be a sign of alcoholism.

RAMOND'S SIGN—Rigidity of the erector spinae muscle indicative of pleurisy with effusion. The rigidity relaxes when the effusion becomes purulent.

RASCH'S SIGN—Fluctuation obtained by applying two fingers of the right hand to the cervix, as in ballottement, and steadying the uterus through the abdomen with the left hand. It depends upon the presence of the liquor amnii, and is an early sign of pregnancy.

RAYNAUD'S SIGN—Dead-finger; a cold, pale condition of the fingers and toes, alternating with heat and redness. It is an early symptom of symmetric gangrene.

REDER'S SIGN—A tender point on the right side above O'Beirne's Sphincter; seen in appendicitis.

(To Be Concluded)

War Work for Young Women.

The Surgeon General's Office, War Department, has issued an urgent call for young women to serve in reconstruction hospitals at home and abroad. The Normal School of Physical Education, Battle Creek, Michigan, which is affiliated with the Battle Creek Sanitarium, wishing to do its share toward winning the war, has inaugurated a course in physiotherapy, which meets the requirements of the War Department. Courses begin October 1 and February 1. Length of course is four months. The curriculum consists of Anatomy, Physiology, Hygiene, Bandaging, Active and Passive Movements, Hydrotherapy, Massage, Electrotherapy, and Clinics.

The medical profession are asked to direct the attention of young women who are planning to engage in war work to this unusual opportunity.

Further information may be obtained from Frank J. Born, M. D., Director of the School.

THE JOURNAL
of The
Kansas Medical Society

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Anomalous Ethics.

The newspapers of Kansas generally reflect the sentiment of the great masses of the people in strongly supporting every effort to prevent the use of alcohol and alcoholic liquors in the state. They are apparently jealous of their reputation in this respect and would resent any inference that they were half-hearted in their support of the principles of prohibition. Alcoholic beverages are carefully barred from their advertising pages, and from their reading columns everything is scrupulously excluded that does not harmonize with the strongest sentiments on the subject of prohibition.

It does not strike the average reader that there is any inconsistency in the fact that large amounts of advertising space are given to the advertising of patent medicines, and that columns of reading matter are used to extol the virtues of patented remedies whose principle or only virtue lies in their alcoholic content, which varies from 14 to 20 per cent. There is nothing in the name which suggests, and nothing in the literature which informs the reader, that it contains alcohol in any amount.

Endorsing these remedies and proclaiming to the public the great benefits they have derived from their use, will sometimes be found the names of ministers, lawyers of note, well known politicians and women of social and literary distinction, men and women whose reputations for sobriety have been well established and whose sentiments on the subject of prohibition can not be questioned. Such people would be shocked if convinced that the agreeable effects they had observed were due to the alcohol they had imbibed in those remedies.

But the newspapers, the leaders of public opinion—have they been negligent in their scrutiny of the matter which fills their columns, or have they been wilfully careless in that regard? Or perhaps they are not yet convinced, as at least some of the members of our profession seem to be, that alcohol has no place in medicine.

If the moderate use of alcohol is harmful, or injurious to health, then the newspapers are responsible for whatever injurious effects may be caused by the use of patent medicines made up with wine or other alcoholic liquor and a negligible quantity of drugs of indefinite or no therapeutic action. Ignorance of the contents of these remedies is no excuse, for the alcoholic content of any of them may be easily obtained, and the relative importance of other ingredients may be readily learned from the Board of Health. If such a use of alcohol is injurious, the newspapers in the state should be prohibited from advertising those patent medicines containing large quantities of alcohol and druggists should be prohibited from selling them.

If such use of alcohol is not injurious, if alcohol judiciously administered has any medicinal value, physicians should be permitted to prescribe or dispense it in such form and at such times as their judgment determines the need.

Can the Old Physician Come Back?

Most men who have practiced medicine for from twenty to thirty years begin to slow down. They accomplish less work, they are less thorough and systematic in their examinations—depending more upon

intuition or observation perhaps—and are prone to follow along the older lines of treatment. They may be no less successful as practitioners than the younger men in the profession, for their experience is of great value to them. But they depend too much upon it, they study less, and are less ready to accept new ideas than in their younger days. In a few years they have fallen behind and realize it. They are unable to discuss medical topics in modern terms and along progressive lines, and they fall out of touch with the younger and more aggressive men. While they have stood still medicine has advanced by rapid strides.

The old man who has slowed down—perhaps stopped for a time—can come back if he will, but it means an amount of perseverence which few of us have, and an endless amount of work which few of us are willing to undertake. The medicine of today is written in a different language from the medicine of thirty years ago, and it would be impossible for the man who stopped then to get much out of it. Those who have trailed a little, but who have kept up communicating lines with the vanguard, will have some difficulty in catching up, but when they come in sight of the main drag their courage and enthusiasm will carry them on.

One may go to medical centers for a few weeks and in the clinics there pick up a little interest and perhaps learn a few of the newer methods of doing things—get a little stimulation, at least—but that is not enough for the man who has fallen behind. There is a great deal lying along the road between his last stopping place and these clinics that he must pick up, if he really comes back. He will need a new library and will need to give it very thorough and systematic study. He will need to study some physiology and particularly what has been discovered in regard to the internal secretions. He will need some physiologic chemistry and he will find a great deal of new material along the line of dietetics. If he is to put himself in touch with modern medicine, he will need to read a great deal of material on infection and immunity. In addition to all this, one will need to follow very closely a few of the best medical journals.

A great deal of time for reading and study is required by every physician who keeps up with medical progress, and the man whose business is so large that he has no time for study soon gets out of the habit, he falls behind in his diagnosis and his treatment, his business gradually drops off, and then he has a chance to try to come back. One wonders if it is preferable to do a moderate business for a lifetime or to do a very large business for a dozen years and then retire.

In the latter case, especially if one has earned and laid by a competence, he may retire and enjoy himself according to his tastes, at any rate he does not need to depend upon his practice for a living. However, although everyone plans and looks forward to it, very few, whether financially able or not, ever reach that time when they are willing to retire from the practice of medicine. The few who have retired are not happy or contented and would welcome an opportunity to take up the work again—if they could.

The man who does a moderate business rarely finds himself in a financial situation that will permit of voluntary retirement, but he has had time to keep up his studies, and, if he has done so, will be happier than the man who has earned a competence at the expense of his mental equipment, whether he retire or not.

———R———

Room for All.

Those who ascribe other motives than duty and patriotism to those physicians who have given their services in the war are only to be found among those who, for various reasons, are still at home.

It has been suggested that many see in the war a chance for advancing their professional standing and increasing their business when the war is over. Perhaps so, but we are willing to credit them with a lot of patriotism mixed with good business foresight. At any rate, the men who

give up their practices to care for the sick and injured soldiers, both here and over there, are entitled to every honor bestowed upon them and every business advantage coming to them when the war is over. If you don't feel like clapping your hands and shouting when one of our Kansas boys in the service over there gets an honorable preferment, an advancement in rank or a Croix de Guerre—go take something for it and try to come clean.

Those who are unable to get commissions in the army will have plenty of work to do at home for the next few years, and if they devote their time and thought to it will no doubt be quite willing to surrender a part of their business to the boys when they come back. It seems to be the general impression among the older men who stay at home that the end of the war will be the end of their usefulness in the practice of medicine. There is really no ground for such a gloomy outlook. For some years the annual output of the medical schools has hardly been sufficient to replace the practitioners who have died and supply the requirements for the steadily increasing population. The number of graduates in medicine will necessarily be short of the requirements for several years to come. When our soldiers come home and the medical officers take up the civilian practice again, there will be room for them without crowding out the old fellows who were compelled to fight the battles at home.

Our Advertising Space Is Appreciated.

Believing that you will like to know how your Journal stands with the advertisers, we publish herewith an extract from a letter received a few days ago from one of them:

"Through the constant use of the advertising pages of your Journal, the Publishers' Adjusting Association has built up a collection business among physicians and surgeons that we claim is without a parallel in medical annals. Last year, for instance, accounts placed with us aggregated one million dollars. We attribute a large portion of our success to the use of your Journal, and it is our belief that anyone having a message for the medical fraternity can do no better than to place the same in the advertising space of your Journal.

"The growth of the business of our medical department has been such that the officers have determined to designate the department hereafter as the Physicians and Surgeons' Adjusting Association, owned and operated by the parent organization, whose entire assets are behind the department. The same efficient collection service will be given in the future as in the past and we anticipate that with the new name, our friends and patrons will more easily grasp the scope and worth of our service."

Major Gray.

Dr. Geo. M. Gray, who early in the year was commissioned a Lieutenant in the Medical Reserve Corps and assigned to duty as medical aide to the Governor, has recently been promoted to the grade of Major.

Excerpts—By The Prodigal.

In the July number of this Journal Dr. H. M. Richter, of Chicago, relates his war experience in a German base hospital. He says, "In 1916 Germany was not using any means of disinfection. The wound was opened up very widely and packed with gauze without any idea of disinfection." It would be a favor if the Doctor would tell us what the mortality was with such treatment, as compared with the same class of wounds treated in the base hospitals of the Allies. It may have been a coincidence, but in the same paper the Doctor says, "In one of the earlier wars a part of the English army was cut off by the enemy and 500 were wounded. They were kept away from the main army for fifteen days. They had no dressing, no antiseptics, and only one surgeon. It was impossible to give attention to all the wounded, so finally the men were allowed to do as they pleased. They bathed their wounds in the water of a near-by running brook. After fifteen days they got back to the main lines and found that the total morbidity and the total mortality of the

little band away from the main army was far below the morbidity and mortality of the others." The treatment of these 500 wounded English was medieval, but the results were scientifically up to date—civilized. They were fortunate in not having more surgeons with them. It shows that there were professional meddlers in those days. The results justified the practice of open treatment of wounds. The function of a doctor is to learn what Nature wants to do and help her. If he does not know what Nature wants and tries to do something, he is sure to do the wrong thing. Asepsis protection and non-interference with Nature insures success in the treatment of wounds.

The success of a physician depends on his ability to differentiate between that which is truthfully told and the truth of that which is told. A good judge of human nature with a little definite knowledge makes a safer and more successful practitioner of medicine than a thorough knowledge of medicine and little knowledge of human nature. That is the reason it is said that a doctor is born, not made. Any ordinary human intelligence can be taught and learn medicine, but to be able to understand and comprehend the workings of the human mind is more or less an intuition. The same principle holds good in mathematics, in music, and in the sciences and arts. A good diagnostician is a good judge of human nature. He gets the confidence of his patience by his confiding and listening attitude, convincing him that the doctor believes him, and the patient becomes a willing subject. He places implicit confidence in such a doctor and confidence and the first and essential element of success in restoring the patient to health. On the same principle that a physician may succeed if others do not have confidence in him, he cannot succeed unless he has confidence in himself. This self-confidence—not egotism—begets confidence in others, is psychologically imparted to the patient. And since a vast majority of diseases are self limited, palatable agents can be given, even placebos, and the doctor need not be haunted with a fear that he has made his patient worse or killed him.

The doctor who studies himself thoroughly, puts himself off to one side and mirrors himself without prejudice, measures himself by watching and associating himself with those who are failures as well as the successful physicians will be able to avoid the quicksand of failure and to build on some solid rock of success to a great degree and make up to some extent for his lack of intuition.

The success or failure of a physician is measured by the percentage of his mortality table.

"The strongest motive action, the most powerful mainspring within us all, is the sexual desire. It is stronger in its influence, controls more men, causes the commission of more crimes and more good deeds than any other impulse."

Is This True?

Baldheaded men and billy goats are immune to tuberculosis.

One On the Topeka Examining Board.

The little Irishman was being examined for admission to the army. He seemed all right in every way except one. The doctor said, "You're a little stiff." Instantly the Irish blood boiled as the applicant replied, "You're a big stiff."

Dr. Munn and His Auto.

When Dr. Munn got his first auto he couldn't run it very well, but his folks and friends wished to see how it would work as soon as possible. He loaded the machine to its capacity and started out toward Rossville. Everybody was delighted and Munn was proud to know that he could drive so well without getting into trouble. But after while all decided it was getting late and time to turn homeward. It then dawned on Munn to his horror that he did not know how to turn

the machine on a country road.

"Sorry, but I'll have to keep on going until we come to a town," said Munn. "I know how to run around a block." He kept on going fourteen miles before he found a town (Manhattan) that he could turn around in.

UNANSWERED.

Little girl entertaining the lady caller while her mother was dressing.

Little Girl to Lady: "Have you a little girl?"

Lady: "No, dear, I have no little girl."

Pause.

Little Girl: "Have you a little boy?"

Lady: "No, dearie, I am sorry to say I have no little boy either.

Long pause.

Little Girl: "What are yours?"

It is claimed that only about five per cent of the lower animals are defective at birth. This is a better showing than the "genus homo" can make.

Oculists have found that a peculiar kind of eye strain is caused by persons reading while lying down. That would be called reclining or horizontal heterophoria, I suppose.

It is essential that every practicing physician should be able to diagnose iritis and glaucoma.

It is not so much in knowing a whole lot as in knowing a little and how to use it that counts.

A good doctor is a close observer and hence can see things at a distance. He avoids future trouble by meeting it now.

IF YOU HAVE A COLD
WEAR A MASK.

They are doing it in Europe.

The diseases most feared by the armies in Europe are those developed from coughs and colds. They are communicated mainly in conversation. Spanish influenza is one of the diseases prevalent over seas and America will in all probability have its turn the same as the Russian epizootic and the pink eye here in the 70's.

A doctor who never does any more than he gets paid for never gets paid for any more than he does, and the world soon gets onto his curves.

Progress and advancement in a profession is made by men giving more to the profession than they get out of it.

The late Robert G. Ingersoll asked, "Why is good health not contagious as well as disease?" That question was asked over a quarter of a century ago. The present day physician would answer, "Good health is contagious."

A happy physician brim full of vitality and suggestive treatment at the psychological time makes health contagious. The practice of medicine and surgery has no place for a puny, sickly, crabby, grouchy, neurasthenic doctor.

The safe and successful physician and surgeon studies how little he can interfere with Nature in the treatment of his patient. The fussy meddlesome doctor tries to interfere with Nature and show her that he can beat her, hands down—and fails.

BOOKS.

1917 Collected Papers of the Mayo Clinic, Rochester, Minnesota.

Octavo of 866 pages, 331 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $6.50 net.

The 1917 collection of papers of the Mayo Clinic is fully up to the standard of the former editions. It is a high class publication in every way. The plates are numerous and of excellent grade.

These papers cover a great variety of subjects and all are intensely interesting. It is impossible to select a few that are more worthy of mention than the others, nor does space permit us to give particular notice to all of them. One who wishes

to know what is going on in the medical world will do well to read this collection.

The Hospital as a Social Agent in the Community.

By Lucy C. Catlin, R.N., Director of Social Service Work and Executive Director of the Out-Patient Department of Youngstown Hospital, Ohio. 12-mo of 113 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $1.25 net.

The author has presented in a very convincing way the great importance of the social worker in connection with hospitals. Whether the hospitals shall assume the direction of the social worker, become, in other words, the social agent, does not seem to be so definitely established. Illustrative cases are related which bring out very clearly the close relation between the social and medical needs of the unfortunate. The genuine sympathy of the author for the cause she has so ably espoused is manifest throughout the book.

A Laboratory Manual of Qualitative Chemical Analysis.

By A. R. Bliss, Jr., M.D., Ph.G., Professor of Pharmacology, School of Medicine, Emory University, Atlanta, Ga.; formerly Professor of Chemistry and Pharmacology, Graduate School of Medicine, University of Alabama. Second edition, revised and reset. 194 pages, with working tables. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.25 net.

This book is particularly adapted to the needs of the students in dentistry and medicine and will facilitate the laboratory courses required of them. In the arrangement of the text the author has been able to utilize space to the best advantage. The tests for each member of a group are first given and then the procedure for the separation of that group. It is condensed into a small volume that yet seems to contain all that is essential for the student's instruction.

The Treatment of War Wounds.

By W. W. Keen, M.D., L.L.D., Emeritus Professor of Surgery, Jefferson Medical College, Philadelphia. Second edition, reset. 12-mo of 276 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.00 net.

The second edition of this little book, following so closely upon the first, is indicative of the demand created for it. The second edition has been rewritten and is practically a new book. A considerable amount of space has been given to the Carrel-Dakin method of the treatment of wounds.

It is needless to say that Dr. Keen's effort will be much appreciated by those in the service as well as those who anticipate entering the army.

The Medical Clinics of North America.

Volume 1, No. 6. (The Southern Number, May, 1918.) Octavo of 224 pages, 35 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper, $10.00; cloth, $14.00.

In the Southern Number of the Medical Clinics will be found reports of clinics held by McElroy of Memphis, Bel of New Orleans, Minor of Ashville, Fontaine of Memphis, Bass of New Orleans, Wilson of Charleston, Gibbes of Columbia, S. C., Paullin of Atlanta, Monroe of Charlotte, N. C. There are also contributions by Major McLester, M. R. C., Royster of Norfolk, Snyder of Birmingham and Deaderick of Hot Springs.

The subjects treated are all of general medical interest.

The Surgical Clinics of Chicago.

Volume II, Number 3 (June, 1918). Octavo of 253 pages, 62 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bimonthly. Price per year, paper, $10.00; cloth, $14 00.

In the Surgical Clinics for June will be found the usual number of very interesting reports. Of particular interest to all of us is the clinic by Eisendrath on "Injuries of the Chest in Civil Life and War." A variety of cases were shown and the report is illustrated with a number of very excellent plates.

One of the very timely articles is by E. H. Ochsner on "Potential and Acquired Static Flatfoot." Methods for correction are described and well illustrated.

In this number will also be found a very interesting clinic by Shambaugh on "Surgical Affections of the Nose, Throat and Ear."

Clinical Diagnosis.

A manual of laboratory methods. By James Campbell Todd, M.D., Professor of Pathology, University of Colorado. Fourth edition, revised and reset. 12-mo of 687 pages with 232 text-illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $3.00 net.

This book is of convenient size for the

use to which it is to be put, and the text is sufficiently concise to make it valuable for office or laboratory purposes. There is an introductory chapter on the use of the microscope in which one will find some very serviceable suggestions. Following in regular order are described the methods for examining the sputum, urine, blood, stomach contents, feces. Then there is a chapter on animal parasites, one dealing with miscellaneous examinations, one describing bacteriological methods, one concerning the preparation and use of vaccines, and a chapter on sero-diagnostic methods.

Diseases of the Male Urethra.

By Irvin S. Koll, M.D., Professor of Genito-Urinary Diseases, Post-Graduate Medical School and Hospital, Chicago. Octavo of 151 pages, with 123 illustrations, several in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $3.00 net.

After describing the anatomy of the male urethra the author gives a short history of gonorrhea, then discusses the bacteriology, pathology, symptomatology, diagnosis, course and treatment of the disease. A chapter is devoted to the complications of gonorrheal urethritis, a chapter to stricture, one to non-gonorrheal urethritis, and one on urethrorrhea, prostatorrhea and spermatorrhea. A chapter is devoted to tumors of the urethra and finally the subjects of impotence and sterility are discussed.

Volunteer Medical Service Corps.

The Council of National Defense authorizes the following:

Many thousands of blanks for enrollment of the legally qualified men and women physicians of the country in the reorganized Volunteer Medical Service Corps are being mailed by the Chairman of the General Medical Board of the Council of National Defense. With the blank are enclosed a letter and a folder giving all details as to the organization.

The blank which applicants are asked to fill out reads:

APPLICATION FOR MEMBERSHIP IN THE VOLUNTEER MEDICAL SERVICE CORPS AUTHORIZED BY COUNCIL OF NATIONAL DEFENSE.—APPROVED BY THE PRESIDENT OF THE UNITED STATES.

(Spaces for date, full name, street, city and state addresses.)

1. Date of birth.
2. Place of birth.
3. If foreign born, when did you become a resident of the United States?
4. When and where naturalized? How?
5. Are you single, married, widowed, or divorced? Nationality? Color? Height? Weight?
6. State high school, academy, college, or university you have attended, with dates of attendance, graduations, and degrees received.
7. Give all literary or scientific degrees you have received and names of institutions granting them, with dates.
8. With what languages or branches of science are you familiar?
9. When and where graduated in medicine?
10. When and where licensed to practice medicine?
11. Name principal medical societies of which you are a member. (Do not abbreviate.)
12. What specialty of medicine do you practice?
13. Proportion of time devoted to specialty?
14. Clinical experience in specialty? Institution? Number of years?
15. State all past hospital services. Hospital. Capacity. Date.
16. Present hospital connections. Hospital. Department. Capacity.
17. School and teaching positions occupied in the past. School. Capacity. Date.
18. School and teaching positions now occupied. School. Department. Capacity.
19. State all past experience in industrial or railroad medicine and surgery. Name and address of plant. Type of service (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) Duration of service.
20. State all present connections with

industries or railroads. Name and address of plant. Type of service (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) Time devoted to each plant.

21. State military, naval or public health experience you have had.

22. Are you a federal, state, county, or municipal officer? State exact designation of your office.)

23. Are you engaged in enterprises other than medicine? If so, what?

24. Have you followed any occupation, medical or otherwise, not already noted?

25. Have you previously been an applicant for entry into the United States Service? Service. When. Where. Result. (If rejected, state why.)

26. I have not applied for appointment in the Medical Reserve Corps of the Army, the Naval Reserve Force, or the Public Health Service owing to—(Check reason):

a. Physical disability. (State disability in detail.)

b. Over age (55). (State age in years.)

c. Essential institutional need. Name of institution. Position. Name and address of chief executive.

d. Essential community need. Approximate population. Number of physicians now practicing in your community.

e. Essential to Health Department. Name of department. Position. Name and address of chief of department.

f. Essential to industries. Name of plant. Position. Name and address of chief executive.

g. Essential to medical school. Name of medical school. Position. Name and address of dean.

h. Essential to Local or Medical Advisory Boards. Name and address of Board. Position.

i. Dependents. Number of dependents, including self but not employees. What proportion of your income or that of your dependents is derived from sources other than the practice of your profession? Do other persons contribute to the support of your dependents? Have you or your dependents other immediate relatives who could provide support for your dependents?

j. Sex. (State your sex.)

k. Religious conviction, not a citizen, or other reasons. (State reason.)

27. Are you available for any of the following services:

a. Consultant. Medical service. Surgical service. Public health service. Special service—What?

b. Institutional. Laboratory. Administrative. Medical service. Surgical service. Special service—What?

c. Medical service for industries. Part time. Full time. Own community. Other communities. Kind of work

d. Local or Medical Advisory Boards.

e. Reclamation of registrants rejected for physical unfitness.

f. Service to needy families and dependents of enlisted men.

g. Sanitation.

h. Miscellaneous service.

28. Check the Governmental service in which you would prefer to serve, if selected:

a. Medical Reserve Corps of the Army.

b. Naval Reserve Force.

c. Public Health Service.

NOTE.—Wherever practicable, your preference will be given consideration. However, the exigencies of war may render it necessary to ask you to do service other than that indicated as your choice.

29. Personal references. (Name three, at least one physician.)

I hereby make application for membership in the Volunteer Medical Service Corps of the United States. I certify that, to the best of my knowledge and belief, the answers to the preceding questions are true and correct in every respect. I pledge myself to abide by the rules and regulations of the Corps; to apply for a commission in the Medical Reserve Corps of the Army, the Naval Reserve Force, or for appointment in the Public Health Service when called upon to do so by the Central

Governing Board; and to comply with any request for service made by the Central Governing Board.

(Signature) .....

(Present Post-office address) .....

An outline of the purpose and scope of the Volunteer Medical Service Corps, contained in the folder, is as follows:

Volunteer Medical Service Corps organization:

1. Provides means for obtaining quickly men and women for any service required.

2. Furnishes recommendations and necessary credentials to assure the best of medical service both military and civil.

3. Determines beyond question the attitude of the individual toward the war.

OBJECT OF CORPS.

1. Placing on record all medical men and women in the United States.

2. Aiding Army, Navy, and Public Health Service in supplying war medical needs.

3. Providing the best civilian medical service possible.

4. Giving recognition to all who record themselves in Army, Navy, Public Health activities, or civilian service.

WORKING PLANS.

All matters pertaining to the organization will be under the direction of a Central Governing Board, authorized by the Council of National Defense and approved by the President of the United States, and its affairs will be conducted from the general headquarters of the Volunteer Medical Corps at Washington, D. C., under the Council of National Defense.

OPERATING SYSTEM.

1. Central Governing Board of twenty-five.

2. Forty-nine state executive committees.

3. One representative in each country in every state.

NOTE.—(*a*) All men to be appointed to state and county committees preferably over 55. (*b*) Each state executive committee to consist of five in the smaller states and one additional number in each of the larger states in proportion to each 1,000 medical inhabitants (to be nominated by state committees, medical section, Council of National Defense, from among their own members.) (*c*) Each county of 50,000 population or under should have one representative. All counties having over 50,000 population should have one additional county representative for each 50,000 population or fraction thereof. All county representatives to be nominated by the state executive committee.

DUTIES.

Central Governing Board. — To receive and pass upon all appointments.

State Governing Boards. — To receive facts from county representatives and make recommendations to Central Governing Board.

County Representatives. — To submit facts to state committees according to advice from central governing board or state executive committees.

Under the reorganization, every legally qualified physician, man or woman, holding the degree of Doctor of Medicine from a legally chartered medical school, who is not now attached to the Government service, and without reference to age or physical disability, may apply for membership and be admitted if qualified; whereas, the original organization admitted only those who for various reasons were ineligible to membership in the Medical Reserve Corps. The organization will mobilize the medical profession in order to provide for the health needs of the military forces and the civil population, and the recording and classifying of doctors will afford means of obtaining quickly men and women for any service required.

To date about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in government service or have volunteered their services. Up to July 12 the Surgeon General had recommended to the Adjutant General 26,733 doctors for commissions in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes

26,73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty.

The need for using wisely the service of the medical men, in view of the universal war activities, is indicated when it is known that in the five weeks ended August 2 there were 2,700 medical officers commissioned in the Army, Navy, and Public Health Service—or at the rate of 540 per week. This rate at which enrollment is proceeding is the cumulative result of the operation of all the machinery which has been in process of setting up since the United States entered the world war. While the number commissioned in the five weeks mentioned may seem large, it is not much greater than the rate at which medical men have been receiving their commissions during the past year. There are now 28,674 medical officers commissioned in the three services—26,027 in the Army, 2,427 in the Navy, and 220 with the commission of Assistant Surgeon in the United States Public Health Service. Of the 2,700 commissioned in the five weeks ended August 2, there were 2,527 in the Army, 169 in the Navy, and four in the United States Public Health Service. Also forty doctors designated as Acting Assistant Surgeons have been taken on in the Public Health Service in the last two months, twenty-one for work in extra-cantonment zones, fourteen for special venereal disease work, and five for marine hospitals. The 26,027 in the Army medical service comprise 933 in the Medical Corps, the regular Army service; 23,-531 in the Medical Reserve Corps; 1,194 in the Medical Corps of the National Guard, and 369 in the Medical Corps of the National Army.

It is estimated that at least 50,000 doctors will be necessary eventually for the Army. It can readily be seen that with the enrollment of these active men, their places in communities and institutions must be cared for and the work, therefore, throughout the country must be so systematized and co-ordinated that the civilian population may not suffer. An important aspect is the need for medical men in the communities where munitions and other vital war products are being made.

The Volunteer Medical Service Corps, supervised by the Central Governing Board now named, will thoroughly care for these needs.

In connection with the mailing of membership blanks for the Volunteer Medical Service Corps to all legally qualified men and women doctors of the country, Dr. Franklin Martin, chairman of the General Medical Board of the Council of National Defense, says:

"Great as has been the response to the appeal for doctors, it must be greater. It is imperative that every doctor not already in a government service fill out, sign and return the blank to the offices of the Central Governing Board, Council of National Defense, Washington, at once. We believe thousands will do this, as they are anxious to be enrolled as volunteers for the Medical Departments of the Army and Navy before registration under the new draft law goes into effect. The appeal for enrollment in the Volunteer Medical Service Corps, which President Wilson has formally approved, is an official governmental call to service. This will place the members of the medical profession of the United States on record as volunteers, available for classification and ready for service when the call comes."

———R———

Yeast in the Treatment of Acne.

As already stated, the importance of bakers' yeast in the treatment of acne vulgaris was pointed out by Hawk and collaborators (loc. cit.), who used it with success in a variety of conditions. Brewers' yeast had for a long time been used with success in the treatment of acne. It possesses, however, the disadvantages of

non-availability and non-uniformity. Hawk treated seventeen cases of acne vulgaris with one to three cakes of baker's yeast daily. Many of these cases had resisted other treatment. In from one week to two months all the cases of acne vulgaris had improved or were cured. Hawk states: "Whether the success of yeast in acne vulgaris and acne rosacea is due alone to its laxative action or to some fixed effect on the intestinal tract we are unable to say. The preparation was laxative in all these cases. We consider that yeast is fully as successful as any other remedy in furunculosis, acne vulgaris and acne rosacea."

As stated, yeast has been used at various times in the treatment of acne, and with success. There seems to have been a prejudice in favor of brewers' yeast, but this the article by Hawk should remove.

Among the medical authors who have used yeast with success in acne are Saalfeld (Deutsche Med. Wochenschr, V. XXXII, No. 29; July 19, 1906, p. 1163) and Paschkis (Wiener klin. Wochenschr, V. XV, No. 31; July 31, 1902, p. 791). Saalfeld noticed a diminution of the indican in the urine of his patients, or even its disappearance, under yeast treatment. The possibility of the diminution of blood-sugar is to be thought of. Paschkis employed both brewer's yeast and baker's yeast with good effect.

The value of yeast in acne is freely acknowledged in the text books. Thus, yeast or its preparations is recommended in the text books of Darier (1909), Walsh (1913), Sibley (1916), and Gougerot (1917). Chatelain (1910) has used bakers' yeast in acne without seeing a great difference between the results of brewer's yeast and baker's yeast.

Acne due to chemicals should be treated by the removal of the cause.

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Assistant Physician U. S. Penitentiary.

The Journal of the Kansas Medical Society:

The Department of Justice has authorized me to employ an assistant physician for the United States Penitentiary, Leavenworth, Kansas, at an annual compensation of fifteen hundred dollars and quarters with board. The applicant must be graduated from a reputable medical school, of good character and temperate.

This position will require presence on the ground at night and such portion of the day as the Warden may see fit.

Applications for this position must be made in person to the Warden of the Institution and the applicant must at the same time present his credentials.

Believing this may be of use to your profession, I request that you give it publicity. Respectfully,

THOS. W. MORGAN, Warden.

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County Representatives, Volunteer Medical Corps in Kansas

Appointment of county representatives in Kansas to handle locally the work of the central governing board of the volunteer medical service corps has been announced by the National Council of Defense. The Kansas state executive committee, announced some time ago, is composed of Dr. S. J. Crumbine, Topeka; Dr. George M. Gray, Kansas City; Dr. J. F. Axtell, Newton; Dr. Charles S. Huffman, adjutant general, Topeka; Dr. Samuel Murdock, Jr., Sabetha; Dr. Joseph E. Sawtell, Kansas City; Dr. David W. Basham, Wichita. The purpose of this committee is to co-operate with the central governing board in prosecuting all activities pertaining to the mobilization and enrollment of members in the corps throughout the state.

The county representatives are:

Allen—Dr. R. N. McMillen, Iola.
Anderson—Dr. J. A. Milligan, Garnett.
Atchison—Dr. E. T. Shelly, Atchison.
Barber—Dr. H. Gilbert, Medicine Lodge.
Barton—Dr. E. E. Morrison, Great Bend.
Bourbon—Dr. Van Velzer, Fort Scott.
Brown—Dr. L. Reynolds, Horton.
Butler—Dr. F. A. Garvin, Augusta.
Chase—Dr. J. F. Shelly, Elmdale.
Chautauqua—Dr. L. D. Tont, Cedarvale.
Cherokee—Dr. R. B. English, Columbus.
Cheyenne—Dr. B. F. Jeffres, St. Francis.
Clark—Dr. W. F. Taylor, Ashland.
Clay—Dr. G. W. Bale, Clay Center.
Cloud—Dr. S. C. Pigman, Concordia.
Coffey—Dr. J. C. Fear, Waverly.
Comanche—Dr. M. R. McCroskie, Wetmore.
Cowley—Dr. H. L. Snyder, Winfield.
Crawford—Dr. D. O. Munson, Pittsburg.

Decatur—Dr. L. C. Tilden, Oberlin.
Dickinson—Dr. J. N. Deiter, Abilene.
Doniphan—Dr. Wm. M. Boone, Highland.
Douglas—Dr. W. C. McConnell, Lawrence.
Edwards—Dr. C. A. Boyd, Belpre.
Elk—Dr. F. L. DePew, Howard.
Ellis—Dr. F. K. Meade, Hays.
Ellsworth—Dr. Alfred O'Donnell, Ellsworth.
Finney—Dr. Wm. J. Stilson, Garden City.
Ford—Dr. C. E. McCarty, Dodge City.
Franklin—Dr. H. L. Kennedy, Ottawa.
Geary—Dr. W. A. Smiley, Junction City.
Gove—Dr. J. H. McNaughton, Gove City.
Graham—Dr. I. B. Parker, Hill City.
Grant—Dr. G. R. Hickok, Satanta.
Gray—Dr. G. W. Hollenbeak, Cimarron.
Greenwood—Dr. W. T. Grove, Eureka.
Hamilton—Dr. Chas. F. Harrison, Syracuse.
Harper—Dr. A. E. Walker, Anthony.
Harvey—Dr. Max Miller, Newton.
Haskell—Dr. L. V. Miner, Santa Fe.
Hodgeman—Dr. John F. McDonald, Jetmore.
Jackson—Dr. E. W. Reed, Holton.
Jewell—Dr. E. L. Raynolds, Mankato.
Johnson—Dr. F. F. Green, Olathe.
Kearney—Dr. G. F. Johnson, Lakin.
Kingman—Dr. B. H. Pope, Kingman.
Kiowa—Dr. P. F. Wesley, Haviland.
Labette—Dr. G. W. Gabriel, Parsons.
Leavenworth—Dr. J. L. Everhardy, Leavenworth.
Lincoln—Dr. Otto Dierker, Sylvan Grove.
Linn—Dr. T. W. Warner, Parker.
Logan—Dr. C. C. Winslow, Oakley.
Lyon—Dr. C. S. Trimble, Emporia.
Marion—Dr. B. T. Prather, Peabody.
Marshall—Dr. Wm. D. Patterson, Marysville.
McPherson—Dr. J. G. Hall, McPherson.
Meade—Dr. C. B. Leslie, Meade.
Miami—Dr. Melton, Hillsdale.
Mitchell—Dr. W. H. Cook, Beloit.
Montgomery—Dr. A. E. Miner, Independence.
Morris—Dr. J. A. Woodmansee, Dunlap.
Morton—Dr. W. V. Tucker, Elkhart.
Nemaha—Dr. Willard A. Haynes, Sabetha.
Neosho—Dr. A. N. Davis, Chanute.
Norton—Dr. W. C. Lathrop, Norton.
Osage—Dr. F. F. Schenk, Burlingame.
Osborne—Dr. B. F. Chilcott, Osborne.
Ottawa—Dr. G. E. Ganoung, Minneapolis.
Pawnee—Dr. L. R. Sellers, Larned.
Phillips—Dr. A. E. Nelson, Phillipsburg.
Pratt—Dr. O. F. Searle, Bellevue; Dr. H. W. Walker, Pratt.
Rawlins—Dr. W. C. McIrwin, Atwood.
Reno—Dr. C. Klippel, Hutchinson.
Republic—Dr. C. M. Arbuthnot, Belleville.
Rice—Dr. M. L. McCrea, Sterling.
Riley—Dr. Geo. H. Ross, Manhattan.
Rooks—Dr. W. B. Callender, Stockton.
Russell—Dr. R. A. Stewart, Russell.
Saline—Dr. W. E. Mowery, Salina.
Sedgwick—Dr. H. H. Taggart, Wichita.
Seward—Dr. W. F. Huddleson, Liberal.
Shawnee—Dr. W. E. McVey, Topeka.
Sheridan—Dr. E. D. Beckner, Hoxie.
Sherman—Dr. W. H. Smith, Goodland.
Smith—Dr. C. C. Funk, Smith Center.
Stafford—Dr. J. T. Scott, St. John.
Stanton—Dr. W. F. Hoover, Johnson.
Stevens—Dr. W. E. Bundy, Hugoton.
Sumner—Dr. S. T. Shelly, Mulvane.
Thomas—Dr. V. C. Eddy, Colby.
Trego—Dr. W. Y. Herrick, Wakeeney.
Wabaunsee—Dr. J. C. Bennett, Eskridge.
Wallace—Dr. W. W. Carter, Sharon Springs.
Washington—Dr. Wm. M. Earnest, Washington.
Wilson—Dr. A. G. Flack, Fredonia.
Woodson—Dr. H. W. West, Yates Center.
Wyandotte—Dr. L. F. Barney, Kansas City.

To the Army and Navy.

The following physicians of Kansas have been reported as having accepted commissions in the army and navy since August 1:

C. E. Boudreau, Eldorado	D. Peterson, Latham
A. E. Billings, Topeka	L. S. Coplan, Wellington
F. H. Slayton, Wichita	L. R. McKeehan, Atchison
O. J. Corbett, Emporia	J. W. Cheney, Wichita
H. T. Davidson, Wichita	E. D. Ebright, Wichita
H. R. Seates, Baxter Sp'gs	J. O. Williams, Emporia
C. W. Demott, Independ'ce	V. H. Bantleon, Kansas City
R. O. Preston, Meriden	L. V. Sams, Topeka
R. H. Downing, Wellington	A. J. O'Leary, Burr Oak
W. F. Neinstedt, Hartford	G. R. Gage, Hutchinson
A. B. Ingels, Larned	H. G. Hunsberger, Mt. Hope
J. A. Settle, Reading	N. D. Miller, Topeka
J. C. Caldwell, Wellington	T. M. Agnew, Wichita
R. S. C. Fisher, Wichita	

O. K. Haydon, Elk City—Navy.

Orders to Officers of the Medical Reserve Corps in Kansas.

Lieut. C. E. Shepard, Baldwin City, to Camp Crane, Allentown, Pa., base hospital, from New York. Lieut. C. E. Yates, Vinland, for duty, from Camp Travis.

Capt. C. H. Koontz, Onaga, to Camp Grant, Rockford, Ill., for duty, from Fort Riley. Lieut. J. L. Peppers, Newton.

Capt. G. I. Thacher, Waterville, to Camp Jackson, Columbia, S. C., base hospital, from Camp Crane.

Lieut. J. C. McKinnon, Caldwell, to Camp Kearney, Linda Vista, Calif., for duty, from Portland, Ore.

Major J. D. Riddell, Salina, to Camp Las Casas, San Juan, P. R., base hospital, from Fort Riley.

Lieut. J. A. H. Webb, Stafford, to Camp Lee, Petersburg, Va., base hospital, from New York.

Capt. F. T. Johnson, Jr., Elmdale, to Camp McClellan, Anniston, Ala., for duty, from Camp Upton.

Lieut. C. W. Hall, Hutchinson, to Camp Sherman, Chillicothe, Ohio, base hospital, from Camp Dix.

Lieut. J. M. Marks, Valley Falls, to Camp Upton, L. I., N. Y., base hospital, from Fort Oglethorpe.

Lieut. F. B. Sheldon, Manhattan, to Camp Wadsworth, Spartanburg, S. C., base hospital, from New York.

Lieut. E. J. Frost, Wichita, to Fort Oglethorpe, from New York. Lieut. M. F. Russell, Great Bend, for instruction.

Lieut. T. M. Aknew, Wichita, to New Haven, Conn., Yale Army Laboratory School, for instruction.

Capts. A. A. Shelley, Galena; J. W. Nixon, Girard; G. R. Gage, Hutchinson; E. A. Reeves, Kansas City; H. G. Hunsberger, Mount Hope; C. L. Randall, Neodesha; A. E. Billings, Topeka; J. C. Caldwell, W. M. Martin, Wellington; Lieuts. D. Peterson, Atlanta; W. J. Lowis, Colby; A. J. Turner, Garnett; W. S. Hudiberg, Independence; C. W. Longenecker, Kingman; W. B. Burr, Longton; E. C. Lightfoot, Mineral; H. A. Vincent, Perth; W. V. Hartman, Pittsburg; H. T. Davidson, Wichita, all to Fort Riley for instruction.

Capt. B. H. Jordan, Medicine Lodge, to report to the commanding general, Central Department, for assignment to duty.

Capt. John F. Rudolph, Belle Plaine, to Camp Abraham Eustis, Lee Hall, Va., camp hospital, from Camp Lee.

Lieut. John R. Campbell, Coats, to Camp Beaure-

gard, Alexandria, La., for duty, from Fort Riley.

Capts. Harry L. Chambers, Lawrence, Herbert Atkins, Pratt, to Camp Crane, Allentown, Pa., base hospital, from Fort Riley.

Lieut. W. H. Greider, Topeka, to Camp Dodge, Des Moines, Iowa, for duty, from Fort Riley.

Capt. Robert B. Stewart, Topeka, to Camp Gordon, Atlanta, Ga., base hospital.

Lieut. C. O. Shepard, Independence, to Camp Lewis, American Lake, Wash., as assistant to division surgeon, from Fort Riley.

Lieut. Fred G. Poultee, Horton, to Fort Logan H. Roots, Ark., base hospital.

Lieut. Chester H. Smith, Pittsburg, to Fort Oglethorpe for instruction.

Lieut. J. C. Shaw, to Fort Riley, base hospital, from Fort Oglethorpe. Caps. Clarence E. Boudreau, Eldorado, George C. Mahaffey, Ottawa, Lieuts. Noble E. Naylor, Centropolis, Earl G. Padfield, Salina, for instruction.

Lieut. Orville O. Moore, Topeka, to Fort Worth, Texas, for duty, from Fort Sam Houston.

Lieut. Alden L. Crittenden, Wichita, to New York City, Neurological Institute, for instruction.

Lieut. A. J. O'Leary, Burr Oak, to Camp Beauregard, Alexandria, La., base hospital.

Lieut. E. M. Ireland, Coldwater, to Camp Bowie, Fort Worth, Texas, base hospital.

Capt. A. J. Lind, Kansas City, to Camp Custer, Battle Creek, Michigan, base hospital.

Lieut. R. H. Downing, Wellington, to Camp McClelland, Anniston, Ala., for duty.

Capt. L. S. Coplan, Wellington, to Camp Pike, Little Rock, Ark., base hospital. Capt. R. C. Henderson, Erie, from Rock Island.

Capts. C. W. DeMott, Independence, E. B. Haynes, Madison, Lieuts. A. W. Lovene, Burdick, R. M. Tinney, Norton, B. D. Thomas, Shawnee, to Fort Riley, for instruction. Capt. J. A. Settle, Reading, for temporary duty.

Lieut. R. S. C. Fisher, Wichita, to Fort Sam Houston, Texas, base hospital.

Lieut. C. F. Ensign, Lawrence, to New Haven, Conn., for duty.

Lieut. E. V. Adams, Topeka, honorably discharged.

Capt. F. C. Cave, Winfield, Lieut. F. A. Trump, Ottawa, to Camp Beauregard, La., base hospital. Lieut. L. D. Mills, Greeley, from Fort Oglethorpe.

Lieut. W. H. Iliff, Crestline, to Camp Cody, N. M., Capt. F. H. Slayton, Wichita, base hospital.

Capt. J. N. Sherman, Thayer, to Camp Crane, Pa., from Fort Riley.

Lieut. H. P. Knowles, Sterling, to Camp Pike, Ark., base hospital.

Capt. H. G. Snyder, Seneca, to Camp Zachary Taylor, Ky., base hospital, from Fort Oglethorpe.

Capt. V. H. Bantleon, Kansas City, J. W. Cheney, Wichita, to Fort Oglethorpe, for instruction.

Lieuts. B. B. Mason, Grenola, R. O. Preston, Meriden, to Fort Riley. Capt. L. V. Sams, Topeka, Lieut. Wm. S. Prout, Concordia, R. A. Taylor, Meriden, O. R. Brittain, Salina, J. H. O'Connell, Topeka, A. H. Nosseman, Whitewater.

Lieut. E. F. Clark, Mayfield, to New Haven, Conn., Yale Army Laboratory School, for instruction.

Lieut. E. H. Schlegel, Wichita, to New York Neurological Institute, for intensive training, from Washington.

Capt. H. Wilkinson, Kansas City, to Rockefeller Institution for instruction in the treatment of infected wounds, and on completion to Walter Reed General Hospital.

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Advertising is a necessary substitute for salesmen called to the colors.

Important.

COUNCIL OF NATIONAL DEFENSE
Medical Section
WASHINGTON, August 12, 1918.

FROM: Dr. Franklin Martin, Chairman, General Medical Board, Council of National Defense.

To: The Editor.

SUBJECT: Enrollment of Physicians.

1, On August 8th the following statement was authorized by the War Department, signed by Newton D. Baker, Secretary of War:

"The War Department today has suspended further volunteering and the receipt of candidate for officers' training camps from civil life. This suspension will remain in force until the legislation now pending before the Congress with regard to draft ages is disposed of and suitable regulations drawn up to cover the operation of the selective system under the new law. * * *"

Fearing that this order might be misinterpreted by doctors who would not distinguish between enlistment as a private soldier and enrollment as an officer in the Medical Reserve Corps, on August 9th I asked the Secretary of War to issue a statement making clear this point.

2. In response to this request on August 10th the following statement was authorized by the War and Navy Departments:

"Orders issued by the War and Navy Departments on August 8th suspending further volunteering and the receipt of candidates for officers' training camps from civil life do not apply to the enrollment of physicians in the Medical Reserve Corps of the Army and the Reserve Force of the Navy. It is the desire of both departments that the enrollment of physicians should continue as actively as before so that the needs of both services may be effectively met.

JOSEPHUS DANIELS,
Secretary of the Navy.
NEWTON D. BAKER,
Secretary of War."

3. It is desirable that the definite attention of the medical profession be called to this interpretation in order that en-

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Doctors told us they wanted a bran dish which people would continue. Now thousands of doctors say that Pettijohn's meets that requirement well.

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(1941)

rollment for the Medical Reserve Corps of the Army and the Reserve Force of the Navy which is going on so rapidly at the present time, shall not be interrupted. Trusting that you will give this prominent space in the next issue of your Journal and such editorial comment as you may deem desirable, I am,

Yours very truly,

FRANKLIN MARTIN,

Chairman, General Medical Board.

Deaths.

Lieut. Col. Clarence Leroy Cole, M.C., U. S. Army, San Antonio, Texas, Medical College, Topeka, 1903; aged 41; a Fellow of the American Medical Association; who entered the Army, May 10, 1905, and was in charge of the laboratory at Fort Sam Houston, Texas; who recently had been under treatment at the Walter Reed Hospital, Washington, D. C.; was found dead in his quarters, August 9, from a bullet wound of the head, self inflicted, it is believed with suicidal intent, while suffering from mental depression.

Lieut. Guy Augtin Tull, M.R.C., U. S. Army, Kansas City, Mo.; on duty with the Three Hundred and Fifty-Third Infantry, Camp Funston, Kans.; Kansas Medical College, Topeka, 1895; aged 49; a Fellow of the American Medical Association; and of the American Academy of Medicine; once president of the Clay County (Kansas) Medical Society and surgeon for the Rock Island System; died at his home, July 13, from chronic interstitial nephritis.

Andrew Pearson, Wakefield, Kan., Rush Medical College, 1883; resident physician at the Chiloco Indian Reservation; died in the Presbyterian Hospital, Chicago, July 14.

Mary Dugan Ardery, Garden City, Kan.; Keokuk (Iowa) Medical College, 1891; aged 76; formerly a member of the Kansas Medical Society; who retired from practice several years ago on account of paralysis; died at the home of her daughter in Garden City, July 23.

The Health Officer and the Big Fight.

It is said to take nine men working "over here" to keep one soldier fighting "over there." Clearly, therefore, it is wise to keep the nine workers husky and working as well as the one soldier.

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, October 14-17, to be held under the auspices of the American Public Health Association. Some of the military sanitarians who will address the meetings are Surgeon General Gorgas, Colonel Victor C. Vaughan, and Major William H. Welch of the Army Medical Corps. Other speakers at the general sessions will be George H. Vincent, president of the Rockefeller Foundation, Dr. Charles J. Hastings, president of the American Public Health Association, Dr. W. A. Evans, Assistant Surgeon General Allan J. McLaughlin, U.S.P.H.S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, Dr. Frederick L. Hoffman and others.

As the health of the civil population has a direct bearing upon the winning of the war, mayors and governors are being requested to send their health officers to the conference in spite of the present high cost of government.

The final program will appear in the American Journal of Public Health appearing September 25. For further information write to A. W. Hedrich, Secretary, American Public Health Association, 1041 Boylston St., Boston, Mass.

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WANTED—Woman physician as assistant or partner. No objections to recent graduate. Address "Woman Gynecologist," care Journal.

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When properly applied it adheres closely to sound skin, yet separates readily and without pain from denuded surfaces.

Stanolind Surgical Wax when applied in proper thickness maintains a uniform temperature, promoting rapid cell growth, and assisting nature to make repairs quickly.

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, OCTOBER, 1918 No. 10

Report of an Unusual Case of Foreign Body in Abdomen.

ALFRED O'DONNELL, M.D., Ellsworth, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

C. K., age 27, male, carpenter, single, Kanopolis, Kansas. Admitted July 3, 1916. Chief complaint, foreign body in the rectum.

Past History—Measles, mumps, chicken-pox when a child, had typhoid fever at the age of three, always strong and healthy. August 2, 1915, while in a hay loft fixing a hay carrier on the track, the carrier became loose and he fell about twenty-five feet, alighting on his feet and then on his buttocks. At once he became partially paralyzed from his waist down. Following this accident he had complete retention of feces and urine. He was taken to the hospital six days later and stayed six weeks, being in bed five weeks. He was able to walk fairly well but had to take a strong cathartic to move his bowels and catheterize himself for six months following. Previous to this recent injury he was quite steady on his feet and was delivering ice.

Family History—Mother died, age 64, with goiter. Father 69, living and well. Six brothers alive and well. Three sisters alive and well.

Physical Examination — Patient intelligent and well nourished and no muscular atrophy or loss of strength.

History of Complaint—July 2 at 10 P.M. while in his bed room he was using a large red, white and blue souvenir lead pencil, 12 inches long, "to doctor his piles." He covered the round smooth cap end with mentholatum and in a standing posture inserted it into the rectum four or five inches, which had been his custom for five or six years. Just previous to this operation he had swallowed a small piece of cigar which he had been smoking and noticed that he had felt sick on his way upstairs to his room. Soon after he had inserted the lead pencil he became dizzy and fell backwards, falling quite forcibly on the bed and driving the pencil so far up into the rectum that he could not touch it. The proximal end was sharpened quite bluntly but caught into one of the rectal folds so that it could not be retracted. He became quite sick after this and vomited several times. He suffered considerable pain, but this was probably not so severe on account of an injury to his back which he received August 2, 1915, and which left him partially paralyzed. Dr. Reitzel of Kanopolis was called that night but was unable to remove the pencil in spite of the relaxed and almost insensitive condition of the rectum and sphincters. He brought the patient to the Ellsworth Hospital at 11 A.M. July 3, temperature 100.8, pulse 100, and some marked abdominal distention.

At 1:30 P.M. he was taken to the operating room and attempts were made to remove the pencil per rectum without success. The point seemed to be imbedded in the mucous membrane and completely in the abdominal cavity.

Operation: Incision made in the ab-

dominal wall in medium line reaching up into the umbilicus. On opening the abdomen free purulent fluid was found, distended coils of the bowel protruded through the incision and it was not possible to continue exploration of the abdomen until a distended coil was opened and emptied of gas and contents. The foreign body was found lying in the right half of the abdomen, the upper end resting under the border of the liver and the lower end down in the pelvis, having broken through the pelvic colon. It was found impossible to remove the pencil without enlarging the incision upward. This was done and the pencil removed. The intestinal coils which had been out were returned to the abdomen after being washed off with warm salt solution. No attempt was made to close the wound in the rectum. A liberal gauze drain was inserted in the pelvis down to the wound in the rectum, wound was closed with the exception of the lower two inches which was left for drainage. Patient made uneventful recovery, left hospital in two weeks and in one month was down town.

After the removal of the foreign body the treatment of this case resolved itself into the treatment of the peritonitis which had begun to develop.

Deaver and Peiffer[1] give the following points:

"The prognosis of peritonitis is influenced chiefly by (1) the type and degree of the infection; (2) the situation of the infection; (3) the time of operation; (4) the operation itself; (5) the pre-operative treatment; (6) the post-operative treatment."

It is impossible to lay down a general rule in all cases, but it may be said that it is seldom possible to act too quickly in peritonitis caused by the appendix or by a perforated gastric or duodenal ulcer, while in peritonitis of pelvic origin delay should be the rule. Peritonitis of rapid spreading character seldom comes from the gall bladder, when present it is usually due to perforation and demands quick action. Another important rule in the presence of actual peritonitis is to do the least that is consistent with the ends of the operation and in the shortest time compatible with good work. There is one exception to this rule, that is the performance of a gastroesterostomy at the same time as the closure of a perforated gastric or duodenal ulcer. As to the post-operative treatment the slogan should be, let him get well.

If the operation is performed early and well done there will be little to do and the less done the better. The sharp watch must be kept for complications and symptomatic treatment given for individual conditions as they may arise. The sitting posture, Murphy drip, nothing by mouth and careful nursing are important factors. Water, hot or cold, is used when peristalsis begins, as is shown in the passage of gas or staining of the fluid in the Murphy drip reservoir. Nausea, vomiting and persistent regurgitation and marked distention of the upper abdomen calls for the use of the stomach tube.

[1] N. Y. Med. Jour., CII 977; Deaver, J. B., and Peiffer, D. B.

R

First Aid to the Neurotic.

MAUD S. DELAND, M.D., State Hospital, Topeka.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

As it is of the greatest importance that the first aid to those injured in battle should be of the proper kind, so it is also important that the first aid to those injured in the mental conflicts of life should be a sympathetic understanding of the difficulties that beset the individual, and not a fanatical attempt to mould him to our own particular beliefs. He has already been trying to adapt himself to his environment and failed in the attempt. He cannot pull himself up by his own bootstraps, and we must help him to understand his difficulties and supply him with new motives.

The patients who reach the state hospitals almost invariably present a well-developed and often intractible psychosis. And it is conceded that it is impossible to

do psychoanalysis in imbeciles, dements, seniles or organic cases, in acute maniacal or catatonic excitement and in mute patients. Thus comparatively few cases in state hospitals are subjects for psychoanalysis. It is the general practitioner who gets the cases of hysteria, obsessional and anxiety neuroses, the paranoid conditions and the early dementia praecox cases.

This afternoon I am here not to try to convince you of the value of the Freudian theories, for I have already given you the reasons why I believe in them in a paper published in the Journal of the Kansas Medical Society, but I am here simply and solely to plead with you to investigate the mental life of your patients as carefully as you investigate physical symptoms and to co-operate with the doctors who are making a specialty of mental diseases in order that we may all arrive at the truth. Or if you do not wish to take the time to study and apply psychoanalysis for yourselves at least refer your patients to one making a specialty of this work before they present a well-developed psychosis.

What perhaps all of us desire most is to understand human beings as biological units. One may specialize on gall bladders, stomachs, noses or brains, but this knowledge is most valuable when co-ordinated. It would be well for us to know whether a larger number than normal of the insane suffer from kidney disease or intestinal stasis, but it is just as important to know what mental state attends diseases of the liver or thyroid or heart or lungs. Is there, or is there not, any correlation between mental and physical states? If there is, what is it? If not, what do our mental states result from? As Luther Burbank says: "A knowledge of the battle of tendencies within the plant is the very basis of all plant improvement. It is not that the work of plant improvement brings with it, incidentally, as people mistakenly think, a knowledge of these forces, it is a knowledge of these forces rather which makes plant improvement possible." This is equally true of people. And perhaps if we physicians understood people as well as Luther Burbank understands plants, there might be more improvement in the human race. The teacher may instruct along certain lines, the preacher may preach what he has been taught to believe, and the lawyer may argue from precedent, but it is we physicians who should know not only the livers and stomachs of our patients, but their thoughts and feelings and desires. But we can never know them until we ourselves are able to lay aside all critique, all ideas of what the patient should or should not have done, and investigate the mental life of the patient in an unprejudiced and unemotional manner as we do the appendix.

Equally necessary is the realization that with the patient's heredity and environment, he *could not* be otherwise than what he is. As Burgson so beautifully puts it: "Our duration is not merely one instant replacing another. Duration is the continuous progress of the past, which gnaws in the future and which swells as it advances. The past follows us at every instant; all that we have felt, thought, and willed from our *earliest infancy* is there, leaning over the present which is about to join it, pressing against the portals of consciousness that would fain leave it outside. The cerebral mechanism is arranged just so as to drive back into the unconscious almost the whole of the past, and to admit beyond the threshold only that which can cast light on the present situation or further the action now being prepared. In short, only that which can give *useful* work. At the most, a few superfluous recollections may succeed in smuggling themselves through the half-open door. These memories, messengers from the unconscious, remind us dimly of what we are dragging behind us unawares. But even though we may have no distinct idea of it, we feel vaguely that our past remains present to us. What are we in fact, what is our character, if not the condensation of the history we have lived from our birth—nay, even before our birth—since we bring with us prenatal dispositions?

Doubtless we think of only a small part of our past, but it is with our entire past, including the original bent of our soul, that we desire, will, and act. Out past, then, as a whole, is made manifest to us in its impulse; it is felt in the form of tendency, although a small part of it only is known in the form of the idea."

Another essential to the understanding of the mental life is that man shares with the animals the instinctive trends of procreation and self-preservation and that, as Jung says: "Nature has the first claim on man; only long afterwards does the luxury of intellect come. In our present social conditions the nutritional striving is allowed normal gratification and occasions no trouble. To the instinct of procreation, not only in its strictly sexual meaning but in its transformation into creative energy which is used for mechanisms for allurement and protection of the young and the expression of emotions, Freud has given the name libido. With him it is practically synonymous with our word love." Jung has still broadened this conception until with him the word libido signifies that energy which manifests itself by vital processes and is subjectively perceived as aspiration, longing and striving. And he further states, "It can be a surprise only to those to whom the history of evolution is unknown to find how few things there really are in human life which cannot be reduced in the last analysis to the instinct of procreation. It includes nearly everything, I think, which is beloved and dear to us."

Our present social system demands the suppression of the normal manifestations of the sexual libido both in childhood and the adult, except under certain prescribed regulations. In many cases this suppression is most cruelly and stupidly administered. The child misunderstands its purpose, and is frightened and made to believe itself a great sinner. The conflict between the instinctive trends and the repressing forces causes much mental anguish, and is therefore repressed into the unconsciousness. If this repression is successful the libido is sublimated in the external world of reality. But often these instinctive trends break through the repression and appear in a disguised form. This is especially true at the time the individual develops into manhood or womanhood and has to make new adaptations in life. While Freud lays more stress on the character of the conflicts and repressions of childhood, and the influences of the parents, Jung, while not minimizing these facts, places the cause in the present moment. That is, "The conflict is produced by some important task or duty which is essential biologically and practically for the fulfillment of the ego of the individual, but before which an obstacle arises from which he shrinks, and thus halted cannot go on." Perhaps there is not so much difference in these two views after all, as if the childhood had been different the individual might have met the present condition; and if the present condition had not developed, the childish predisposition would not have produced the illness. But be that as it may, in hysteria this repressed libido is converted into physical symptoms. In the obsessional neuroses it returns in a disguised form such as hypochondriacal, social, or religious anxiety or as various phobias, superstitions, or dipsomania. In dementia praecox this libido is introverted —the patient withdraws from reality.

To again quite Jung, "Just as the normal libido is comparable to a steady stream which pours its water broadly into the world of reality, so the resistance dynamically considered is comparable, not so much to a rock rearing up in the river bed which is flooded over or surrounded by the stream, as a backward flow towards the source. A part of the soul desires the outer object; another part, however, harks back to the subjective world, where the airy and fragile palaces of phantasy beckon." In other words when the libido encounters internal conflict and is repressed, it seeks expression, either through less fundamental trends, as when one disappointed in love takes to religion, or else through a symptom in a neurosis, or goes

back to an infantile manifestation of the original trend and becomes auto-erotic. In other words the libido becomes retrogressive in its manifestations. When plants or animals revert back to primitive forms, we call it atavism; when the libido of an adult expresses itself in an infantile manner we call it regression. This tendency towards regression is not confined to a neurosis or a psychosis. It is present in us all. We long for ease and indolence and old forms, and fear to try that which is new.

When the individual is unable to make new adaptations, there is often present what is called the Oedipus or incest complex. To the strictly literal mind which can grasp this old Grecian myth only in its concrete form, it means that the boy killed his father and married his mother, but the psychological truth, as expressed by Jung, is that the fundamental basis of incestuous desire does not aim at cohabitation, but at the special thought of becoming a child again, of turning back to the parent's protection, of coming into the mother once more in order to be born again.

Freud's idea of the Oedipus complex is perhaps more practical, and we must remember that in this we are dealing with the unconscious and not the conscious life. At first the child is only interested in his own body, is auto-erotic. Then his interest and attachment become greatest for his food-giving and comfort-giving mother. Then the biological trend is followed out and the child's libido is directed toward the parent of the opposite sex. Then as the child grows up, the incest prohibition and social conditions force it to seek the love object outside the family. "Thus the Oedipus complex becomes a measuring rod to determine the grade of evolution of psychological activities looking forward to ultimate social values. The analysis of one's acts shows how far in the scheme of evolution the particular act may be placed, whether it remains an infantile fantasy way of obtaining satisfaction from the father-mother attachment or rejection (according to sex) or a grown-up sublimation way which is socially, and hence individually, valuable." (Jelliffe.) Identically the same energy is utilized, but one is valuable, the other wasted. "In our neurotics we find that when life presents an insurmountable obstacle and they are driven back from the pathway that leads into reality, they regressively reanimate the old pathway of least resistance and seek infantile ways of obtaining pleasure. Our patients give us all sorts of examples of their attachment to past infantile dependence on their parents and thus seek to avoid the burdens imposed by reality. Or again they may live only in dreams of the future and project their infantilism into Paradise." Anything to shirk the responsibilities of the present.

Now on the basis that the past is always with us, that conflict causes repression into the unconscious, that the repressed libido in a disguised or distorted form is causing symptoms, the practical problem is simply one of unearthing the buried complexes and freeing the libido attached to them, so that it can be projected in full consciousness into the world of reality. This cannot be done by simply gaining the confidence of the patient and getting him to tell all he knows, for the trouble is inaccessible to him. If he knew he would cure himself. Freud first tried hypnotism as a means for tapping the unconsciousness, but found that this could be better done and was available in more cases by a method which he termed Psychoanalysis. Now the postulate on which psychoanalysis is based is that "every idea has a basis which is as absolutely determined as any other reality of nature."

All the history that the patient can give is obtained, especially his family and early history, for the family is the child's first training camp, father and mother are at first his sole source of authority and comfort. Then various questions relating to traits, habits, sociability, etc., are asked. All the patient's little habits and mannerisms are noticed, all his little ceremonials as expressed in every-day conduct, for per-

sistent habits are often an infantile manner of obtaining satisfaction at least in fantasy.

When confidence in the physician is established, the patient is placed in a position to be as free from distracting influences as possible, is asked to relax and with an utter absence of all critique, utter freely all thoughts which come to him in connection with his troubles, his childhood or in whatever line the physician sees fit to direct. One of the most important sources of gaining information of the unconscious is through dreams. The patient is asked to tell his dreams or write them out. Then by a method of free association there will be found beneath the manifest content of the dream its latent content. This gives an important clue to what is going on in the patient's mind during the analysis. It is to be particularly noted that there is no meaning in dreams in the sense of the old superstition that to dream of a certain thing has a definite meaning. There is no meaning to anything in the dream until it is brought out by associations in the mind of the dreamer. A pond of water may mean one thing to one person and another thing to another, the meaning is only determined by the particular life and experiences and therefore associations of the dreamer.

Of course the foregoing all sounds very simple, but let not any one be misled into believing that psychoanalysis is a simple or easy thing. It takes more time and patience and hard work to acquire than a surgical technique for we are dependent on the whims and moods of the patient, and have to deal with the very practical problems of resistances, transferences, etc., all of which I have not touched on. For it can easily be seen that if the resistance was great enough to drive the conflict from the consciousness of the patient, and not allow it to be recognized in the symptoms, that resistance is still at work, and can only be overcome by much hard work and patience.

Do not think that psychoanalysis is something applicable only to the neurotic. It is applicable to us all, and were we to submit to a psychoanalysis, and be honest in it, we would all be astonished at ourselves. We would have to get acquainted with ourselves all over again, for there we would find the basis of many of our prejudices which we fondly call principles, our likes and dislikes, tastes and inclinations. Also we would detect the real basis of our opposition to the Freudian psychology and our disbelief in psychoanalysis. The result of digging down into the hidden psyche has brought to light the fact that "he who remains healthy has to struggle with the same complexes which cause the neurotic to fall ill." It is psychoanalysis which furnishes us a key to the understanding of human conduct.

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Clinical Eponymic Signs.

(Continued from Page 223)

REICHMAN'S SIGN—The presence in the stomach before eating in the morning, of an acid liquid mixed with alimentary residues; it is indicative of gastrosuccorrhea and pyloric stenosis.

REMAK'S SIGN—The production, by the pricking of a needle, of a double sensation, the second being painful; it is noted in tabes dorsalis.

REUSNER'S SIGN OF EARLY PREGNANCY —An increase in the volume of the pulsation of the uterine arteries may be perceived through the vagina in the posterior culdesac as early as the fourth week.

REVILLIOD'S SIGN—Inability of the patient to close the eye of the affected side only; it is observed in paralysis of the superior facial nerve in hemiplegia.

RICHARDSON'S SIGN—The application of a tight fillet to the arm as a test of death. If life be present the veins on the distal side of the fillet become more or less distended.

REISS' SIGN — On listening over the stomach in cases of adherent pericardium, the heart sounds are heard loud and metallic in quality.

RINMANN'S SIGN OF EARLY PREGNANCY —Slender cords radiating from the nipple; they are considered to be hypertrophic acini of the glands.

RIPAULT'S SIGN—A change in the shape of the pupil on pressure upon the eye, transitory during life, but permanent after death.

RITTER-ROLLET'S PHENOMENON — Flex-

ion of the foot following the application of a mild galvanic current, and extension following that of a strong current.

RIVIERE'S SIGN—An area of change in percussion note denoting a band of increased density across the back at the plane of the spinous processes at the fifth, sixth, and seventh dorsal vertebræ; a sign of pulmonary tuberculosis.

ROGER'S SYMPTOM—Subnormal temperature during the third stage of tuberculous meningitis, regarded by Roger as pathognomonic of the disease.

ROMBERG'S SIGN — (1) Swaying of the body and inability to stand when the eyes are closed and the feet placed together. It is seen in tabes dorsalis, hereditary cerebellar ataxia, etc. (2) Neuralgic pain in the course and distribution of the obturator nerve, pathognomonic of obturator hernia.

ROMBERG-HOWSHIP'S SIGN—Lancinating pains in the leg occurring in incarcerated obturator hernia.

ROMMELAERE'S SIGN—Diminution of the normal phosphates and chlorids of sodium in the urine is pathognomonic of cancerous cachexia.

ROSENBACH'S SIGN—(1) Loss of the abdominal reflex in inflammatory intestinal diseases. (2) Tremor of the eyelids when the patient is asked to close them, often associated with insufficient closure of the lids. It is seen in neurasthenia.

ROSENHEIM'S SIGN — A friction sound heard on auscultation over the left hypochondrium in fibrous perigastritis.

ROSENTHAL'S SIGN—The application of a strong faradic current to the sides of the vertebral column causes burning and stabbing pains in cases of spondylitis.

ROSER-BRAUN'S SIGN—Absence of pulsations of the dura in cases of cerebral abscess, tumors, etc.

ROTCH'S SIGN—Dullness on percussion in the right fifth intercostal space in pericardial effusion.

ROTH'S SYMPTOM-COMPLEX — "Meralgia paresthetica." Numbness, pain on exertion, and hyperesthesia of the part of the thigh supplied by the external cutaneous nerve.

ROTHSCHILD'S SIGN—(1) Preternatural flattening and mobility of the sternal angle, seen in phthisis. (2) Rarefaction of the outer third of the eyebrows in thyroid inadequacy.

ROUSSEL'S SIGN—Sharp pain on light percussion on the subclavicular region, between the clavicle and the fourth rib; a sign of incipient tuberculosis.

ROVIGHI'S SIGN — Hydatid fremitus; a thrill observed on combined palpation and percussion in cases of superficial hyatid cyst of the liver.

ROVSING'S SIGN—Pressure on the left side over the point corresponding to McBurney's point will elicit the typical pain at McBurney's point in appendicitis, but not in other abdominal affections.

RUMPEL-LEEDE'S SIGN—The appearance of minute subcutaneous hemorrhages below the area at which a rubber bandage is applied not too tightly for ten minutes upon the upper arm; characteristic of scarlet fever.

RUMPF'S SIGN—Fibrillary twitching of muscles in traumatic neurosea.

RUST'S SIGN—At every change of position of the body, a patient suffering from caries or carcinoma of the upper cervical vertebras, supports his head with the hand.

SAENGER'S SIGN—A light reflex of the pupil that has ceased returns after a short stay in the dark, in cerebral syphilis, but not in tabes dorsalis.

SANDER'S SIGN—Undulatory character of the cardiac impulse, most marked in the epigastric region, in adherent pericardium.

SANSOM'S SIGN—(1) Considerable extension of dullness in the second and third intercostal spaces in pericardial effusion. (2) A rhythmic murmur transmitted through the air in the mouth when the lips of the patient are applied to the chestpiece of the stethoscope. It is heard in cases of aortic aneurysm.

SARBO'S SIGN—Analglesia of the peroneal nerve, occasionally observed in tabes dorsalis.

SCHAPIRO'S SIGN — No slowing of the pulse-rate on lying down. Indicative of weakness of the heart muscle.

SCHEPELMANN'S SIGN—In dry pleurisy the pain is increased when the patient bends his body toward the well side, whereas in intercostal neuralgia it is increased by bending toward the affected side.

SCHICK'S SIGN—Stridor heard on expiration in an infant with tuberculosis of the broncheal glands.

SCHLESINGER'S SIGN—In tetany if the patient's leg is held at the knee joint and flexed strongly at the hip joint, there will follow within a short time an extensor spasm at the knee joint, with extreme supination of the foot.

SCHLUNGE'S SIGN—Lack of peristalsis below the seat of intestinal obstruction, with dilatation above it.

SCHULE'S SIGN—Vertical folds between

the eyebrows, forming the Greek letter omega (omega melancholicum), frequently seen in subjects of melancholia.

SCHULTZE-CHVOSTEK'S SIGN—See Chvostek's Sign.

SEELIGMUELLER'S SIGN — Mydriasis on the affected side in cases of neuralgia.

SEGUIN'S SIGNAL SYMPTOM—The initial convulsion of an attack of Jacksonian epilepsy, which indicates the seat of the cortical lesion.

SEITZ'S SIGN — Bronchial inspiration which begins harshly and then becomes faint; indicative of a cavity in the lung.

SEMON'S SIGN — Impaired mobility of the vocal cord in carcinoma of the larynx.

SHELLY'S SIGN—A sago-like eruption on the palate and lips in influenza.

SICAR'S SIGN—A metallic resonance on percussion with two coins on the front of the chest and auscultation at the back, observed in some cases of effusion within the pleura.

SIEUR'S SIGN—A clear, metallic sound sometimes heard in cases of pleural effusion on percussing the chest in front with two coins and auscultating behind.

SIGNORELLI'S SIGN—Extreme tenderness on pressure on the retromandibular point in meningitis.

SILEX'S SIGN—Radial furrows about the mouth, and coincidently in other parts of the face; a pathognomonic sign of congenital syphilis.

SIMON'S SYMPTOM—Immobility or retraction of the umbilicus during inspiration, sometimes seen in tuberculous meningitis.

SKEER'S SIGN—A yellowish-brown ring near the pupillary margin of the iris, observed in the early stage of some cases of tuberculous meningitis.

SKODA'S SIGN — A tympanitic sound heard on percussing the chest above a large pleural effusion or above a consolidation in pneumonia.

SMITH'S SIGN — A murmur heard in cases of enlarged bronchial glands on auscultation over the manubrium with the patient's head thrown back.

SPIEGELBERG'S SIGN — A sensation like that of passing over wet india-rubber, imparted to the finger which presses on and moves along the affected part; it is noted in cancer of the cervix uteri.

STELLWAG'S SIGN—Absence or diminution in frequency of the winking movements of the eyelids and abnormal width of the palpebral aperture; it is seen in exophthalmic goiter.

STERLES' SIGN—Increased pulsation over the cardiac region in intrathoracic tumors.

STERNBERG'S SIGN—Sensitiveness to palpation of the muscles of the shoulder-girdle in pleurisy.

STEWART-HOLME'S SIGN — The patient rests his elbow on the table and the examiner grasps his wrist. The patient then tries to flex his arms against the resistance of the examiner. When the wrist is released, flexion occurs, but is again arrested by the contraction of the triceps, in normal patients, but in hypotomia, flexion of arm continues without action of the triceps.

STILLER'S SIGN — Marked mobility or fluctuation of the tenth rib in neurasthenia and enteroptosis.

STOCKER'S SIGN—In typhoid fever, if the bed-clothes be pulled down, the patient takes no notice; but in tuberculous meningitis the patient resents the interference and immediately draws the clothes up again.

STOKES' SIGN — A violent abdominal throbbing felt on palpation to the right of the umbilicus in acute enteritis.

STRAUS' SIGN—In facial paralysis from a central cause, the hypodermic injection of pilocarpin causes no appreciable difference in the perspiration of the two sides, either as to time or quantity, whereas there is a marked retardation of the secretion on the effected side in severe peripheral paralysis.

STRUMPELL'S SIGN—(1) Dorsal flexion of the foot when the thigh is drawn up toward the body; seen in a paralyzed limb. (2) Dorsal flexion of the great toe in an extremity affected with paresis.

STRUNSKY'S SIGN—A sign for detecting lesions of the anterior arch of the foot. The examiner grasps the toes and flexes them suddenly. This procedure is painless in the normal foot, but causes pain if there is inflammation of the anterior arch.

TARNIER'S SIGN—Effacement of the angle between the upper and lower segments of the uterus; it is an indication of inevitable abortion.

TAY'S SIGN—A red spot seen on the retina of each eye in the region of the macula lutea in amaurotic family idiocy.

TELLAIS' SIGN—Pigmentation of the eyelid in exophthalmic goiter.

TESTIVIN'S SIGN—The formation of a collodion-like pellicle on the urine after removing the albumin and treating with acid and then with one-third of its volume of ether; said to occur during the incubation of infectious diseases.

THEIMICH'S LIP SIGN—A protrusion or

pouting of the lips elicited by tapping the obicularis oris muscle.

THORNTON'S SIGN—Violent pain in the flanks in nephrolithiasis.

TOMA'S SIGN—In ascites from peritoneal inflammation when the patient lies on his back percussion on the right side gives tympany; on the left side, dullness.

TOURRETTE'S SIGN—Inversion of the ratio existing normally between the earthy phosphates and the alkaline phosphates of the urine; it is found in paroxysms of hysteria.

TRAUBE'S PHENOMENON — A double sound, systolic and diastolic, heard over peripheral arteries, especially the femoral, in aortic insufficiency; occasionally also in mitral stenosis, lead-poisoning, etc.

TRESILION'S SIGN — A reddish appearance of the Stenson's duct in mumps.

TROISIER'S GANGLION OR SIGN—Enlargement of the left supraclavicular lymph-glands, an indication of malignant diseases of the intraabdominal region.

TROUSSEAU'S SYMPTOM—The production of paroxysms of tetany by pressure upon the principal nerve trunks or blood-vessels of the parts affected. It is observed in tetany.

TURGENSEN'S SIGN—Crepitant rales; regarded as a sign of tuberculous pleurisy.

UHTHOFF'S SIGN — The nystagmus of multiple cerebrospinal sclerosis.

UNSCHULD'S SIGN — A tendency to cramps in the calf of the legs; it is an early sign in diabetes.

URIOLLA'S SIGN—The presence in the urine of malarial patients of minute black granules of blood-pigment.

VANZETTI'S SIGN—In sciatica the pelvis is always horizontal in spite of scoliosis; but in other lesions with scoliosis the pelvis is inclined.

VIGOUROUX'S SIGN — Diminished resistance of the skin to the galvanic current in exophthalmic goiter.

VINCENT'S SIGN—THE ARGYLL-ROBERTSON PUPIL—One which is miotic and which responds to accommodation effort, but not to light.

VIFOND'S SIGN—Generalized adenopathy seen during the incubation period of the exanthematous fevers of childhood.

VOHSEN-DAVIDSOHN'S SIGN—See Davidsohn's Sign.

VOLTOLINI-HERYNG'S SIGN — See Heryng's Sign.

VON WAHL'S SIGN—(1) Distention of the bowel (local meteorism) above the point at which there exists an obstruction; (2) a scraping or blowing sound, synchronous with the cardiac impulse, heard over an arterial trunk immediately after the partial division, through injury, of the vessel.

WARTHIN'S SIGN—Accentuation of the pulmonary sound in acute pericarditis.

WEBER'S SYMPTOM OR SYNDROME—Paralysis of the motor oculi nerve on the side of the lesion and of the facial and hypoglossal nerves and extremities on the opposite side; it corresponds anatomically to a lesion in the pedunculopontine or upper pontine region.

WEGNER'S SIGN—In fetal syphilis the dividing line between the epiphysis and diaphysis of long bones, which under normal conditions is delicate and rectilinear, appears as a broad, irregular, yellowish line.

WEILL'S SIGN—Absence of expansion in the subclavicular region of the affected side in infantile pneumonia.

WEISS'S SIGN — "Facialis phenomenon." Contraction of the facial muscles upon light percussion; it is noticed in tetany, neurasthenia, hysteria, and exophthalmic goiter.

WERNICKE'S SIGN—Hemiopic pupil reaction. Inaction of the pupil on illumination of the amaurotic half of the eye, when the hemiopia depends upon a lesion of the optic nerve between the chiasm and the external peniculate body.

WESTPHAL'S SIGN—Absence of the patellar reflex; it occurs in lesions of the spinal cord at the level of the reflex center (e.g. tabes dorsalis, paretic dementia), neuritis, certain cases of cerebellar disease, etc.

WESTPHAL-ERB'S SIGN—See Westphal's Sign.

WIDMER'S SIGN — The temperature in the right axilla is distinctly higher than the left; a sign of appendicitis.

WILKS' SYMPTOM-COMPLEX—ERB'S DISEASE—Idiopathic muscular atrophy.

WILLIAM'S SIGN — Diminished inspiratory expansion on the left side in adherent pericardium.

WINTRICH'S SIGN — A change in the pitch of the percussion note when the mouth is opened and closed. It indicates a cavity in the lung.

WOLFER'S SIGN—In hour-glass stomachs fluids pass quickly, but on subsequent lavage the water contains food and foul matter.

WOLKOWITCH'S SIGN — Marked relaxation of the abdominal muscles of the right side in chronic recurrent appendicitis.

WREDEN'S SIGN—Presence in the external auditory meatus of a gelatinous mat-

ter in children who are born dead.

ZAUFAL'S SIGN—Saddle-nose.

ZUGSMITH'S SIGN — Abnormal dullness on percussion in the second interspace for a variable distance on both sides of the sternum. Seen in gastric ulcer and carcinoma.

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An Unprecedented Opportunity for Women.

EMMA WHEAT GILLMORE, M.D.
Chairman Committee of Women Physicians, General Medical Board, Council of National Defense.

The same year that gold was discovered in California, a lone pioneer received the first medical diploma which the United States had issued to a woman. Other colleges shortly followed the example of the one which had opened its doors to Elizabeth Blackwell, and today over fifty coeducational medical schools admit women upon the same terms as men.

There are more than 25,000 American physicians in military service at this writing, and the Council of National Defense is undertaking, through the Volunteer Medical Service Corps — an organization which has President Wilson's approval — the task of classifying the qualifications of ninety thousand more. Of these, about six thousand are women, less than one-third of whom have registered with the General Medical Board.

Women of the profession, unless our qualifications are standardized and on file, can you not see that we are an unknown quality and quantity as far as the Government is concerned? In spite of the overwhelming difference in number—6,000 women and over 100,000 men—and regardless of the fact that over twenty-two centuries have passed since Hippocrates wrote the immortal oath and only sixty-nine years have elapsed since women entered the medical profession, the Volunteer Medical Service Corps has invited them to membership with the same impartial cordiality as it has the men.

During the last week in August application blanks for the Volunteer Medical Service Corps were mailed in franked envelopes to all legally qualified men and women in the United States who were not already in Government service. Presumably a number of women have been overlooked because many of them are not members of medical societies, but this will speedily be corrected if a notification of the omission is sent to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

Meanwhile, medical women who possess a vision will see in the Volunteer Medical Service Corps an incomparable method of organization which will register their qualifications and place them in an identical coded class system with men physicians. This corps is in reality an ideal procedure for mobilizing the military forces of our country for selective medical war service. Incidentally it will place loyal and patriotic medical women by the side of those men who are willing to give themselves. Even though all of them are not elected to membership, their names will be on file with the Government as willing to serve as far as their strength and capability will permit, and no one can point a finger at them and say "slacker."

Will a page be turned over in the history of American Medical Women upon which will be written the qualifications of 6,000 of them, matching that group of English physicians known as the Scottish Women's Hospitals, which was so perfectly organized that they were able to hand over to their Government a constructively organized body of professional women for military service? Or shall we continue, as we have done in sporadic groups for the past sixty-nine years, to demand recognition of men and at the same time neglect to unanimously affiliate with them in recognized medical societies, and to withhold our influence both with pen and vote when medico-social and medico-political and medico-scientific issues are at stake which shake the very foundation upon which medicine rests?

The body politic of the civilized world holds a prominent place for the profession of medicine in the near future. Are we to have a hand in shaping it? The Volunteer Medical Service Corps is big with promise for women of the medical profession if we take advantage of it to put ourselves on record. The response which the Council of National Defense receives from women who apply for membership will tell the tale as to whether they have or have not grasped and taken advantage of the unprecedented opportunity which this world's war for democracy has opened up for them through the medium of the Volunteer Medical Service Corps.

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For artillery, automatic rifles, and small arms, and for ammunition for them, we have spent over $3,700,000,000. Every Liberty Loan subscriber helps to arm our soldiers.

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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What Is Pernicious Anemia?

In spite of the very definite symptom grouping, and the very characteristic blood picture that has been offered us, the problem of what progressive pernicious anemia is still remains to be solved.

From the great mass of literature one derives but a hazy conception of this disease, which seems to have a fairly definite pathology and a great variety of possible etiologic factors. There seems to be no unanimity in fixing the proper limits for the use of the term and no concensus of opinion as to the essential feature in its pathology. While some believe that it should be regarded merely as a symptom-complex which may be caused by a variety of pathological processes, others believe that it should be dignified as a separate clinical and pathological entity.

Whichever of these views be accepted, however, if the clinical picture is sufficiently constant to be distinctive, it would seem that the matter of a discoverable relation to some causative factor should play a less important part in its diagnosis than the numerous controversies indicate. No good purpose can be accomplished by giving one identity to a symptom-complex occurring in a group of cases in which the causes are definitely known, and another identity to a strikingly similar or identical symptom-complex in a group of cases in which the causes have not yet been determined. The presence of known causes does not prove that we have to do with merely a symptom-complex in the one instance, nor does the absence of known causes prove that we have to do with a clinical and pathological entity in the other.

It is very evident, however, that one of the greatest obstructions to a clear conception of the various opinions and theories advanced lies in the very indefinite scope of the term progressive pernicious anemia. While some would limit the use of the term to those cases in which the most thorough examination of the patient fails to show any primary disease, others believe there should be included all those cases which show a characteristic blood picture without regard to etiologic findings. Ewing, for instance, believes that the changes in the blood and marrow described in pernicious anemia result from a peculiar pathologic process which is essentially different from that seen in the majority of secondary anemias, and that when the blood contains megaloblasts and a considerable number of megalocytes with increased Hb, while the lymphoid marrow shows marked hyperplasia of peculiar type, the condition should be called progressive pernicious anemia without regard to its immediate exciting cause.

In a condition in which the deviation from the normal seems to be marked by an unusual process of destruction and an exaggerated process of regeneration, it seems logical at least to conclude that the destructive process should be regarded as the essential pathologic one. And yet, in this particular instance, there are some fairly good grounds for a contrary opinion.

There are sufficient evidences of a very marked and, perhaps, unusual type of hemolysis to be found in the excessive deposits of iron in the liver and other organs, in the hemoglobinuria, the pathologic urobilinuria and the clinical symptoms. There is also evidence that the hemolysis precedes in many instances the appearance of the evidences of unusual hematogenesis and

in some cases death has occurred, apparently from the excessive hemolysis, before any evidence of increased hematogenesis has been established. It has also been shown that from the prolonged effect of certain blood solvents a condition strikingly similar to, if not identical with, progressive pernicious anemia may develop.

There seems to be a considerable number and a considerable variety of influences that are capable of causing an excessive hemolysis, but not in all of them is the hemolysis associated with an excessive or unusual hematogenesis. On the other hand the most characteristic feature of pernicious anemia, or at least the elements of its distinguishing blood picture, result from an unusual or defective hematogenesis.

If we assume that excessive hemolysis is the essential pathologic feature; that the excessive hematogenesis is a regenerative or reparative process; and that the characteristic elements in the blood picture of pernicious anemia are the results of this extreme effort at repair, then these elements of the blood picture are not of so much importance in the diagnosis of the disease as in determining a stage in its progress.

While this view of the pathologic importance of an excessive hemolysis seems to be held by a large majority of contributors to the literature on the subject, there is a very impressive array of supporters of the view that progressive pernicious anemia results through *defective* hematogenesis, and that the characteristic elements of the blood picture result from a defective rather than an excessive hematogenesis. It is claimed by some of these that while excessive hemolysis may precede or occur without a defective hematogenesis, it is of a different kind from that associated with megaloblastic changes; and that only the presence of defectively formed red cells renders such a hemolysis possible. They claim that the megaloblastic degeneration of the marrow is the pathognomonic tissue lesion and excessive hemolysis a constant result.

With the acceptance of this view the diagnosis must of course be based upon the finding of characteristic blood cells resulting from this defective hematogenesis.

It would seem, however, that with either view of the essential pathology of this disease the scope of the term progressive pernicious anemia must be enlarged so as to embrace many of the anemias not now regarded as belonging to the pernicious form.

Upon the constancy of the characteristic blood picture and its definite relation to the pernicious form of anemia there is considerable skepticism among the contributors to the literature of the past few years. Ward (London, 1914) says: "In a typical advanced case the condition of the blood is very striking but the suggestion that the disease can be diagnosed by an examination of the blood alone is fallacious * * *. It is of course true that the 'pernicious anemia' type of blood is more commonly met with in Addisonian anemia than in any other disease, but it is equally true that it may be met with after hemorrhage, in cancer, in those who have been poisoned by certain drugs or their fumes, in many septic troubles, in leukemia and in a variety of other conditions."

Among those who accept the excessive hemolysis as the essential pathologic process it is sometimes suggested that the defective hematogenesis, manifested by the characteristic abnormal blood cells, is the result of certain structural changes in organs which have been permanently damaged by the excessive hemolysis, or the agent which is responsible for the hemolysis. This seems to be borne out by the fact that during the periods of improvement, which occur sometimes without any particular treatment and sometimes are apparently the result of certain remedial measures, the so-called pernicious cells do not disappear from the blood picture.

But one may also interpret the persistence of these cells during the periods of remission, in which the patient is sometimes restored to nearly a normal state of

health, as evidence that the presence of these cells in the blood bears no relation to the symptomology of the disease, and for the same reason no relation to its essential pathology.

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Influenza.

It seems to be the same old influenza which the newspapers have attempted to camouflage under a new name. It is the same old fast-moving soul-disturbing life-destroying epidemic disease that the Italians named *influentia*, the French called *la grippe* and to which the Germans gave a like expressive name, *blitz katarrh*. It has been a more or less freuent visitor to the inhabited portions of the globe since before the Christian era. At least it was claimed by Guiteras that an outbreak of the disease occurred in the Athenian army in 415 B. C.

Some of us have very vivid recollections of the epidemic which reached this country in December, 1889, and spread rapidly over the greater part of the United States. During the period of that epidemic there was much speculation as to the etiologic factor, for it was not until 1892 that a bacillus was discovered in the pus-cells of the tracheal mucus by Pfeiffer, and in the blood by Canon, that could reasonably be credited with its cause.

It was generally conceded by the writers at that time that sudden changes in temperature, moisture and electric conditions of the atmosphere were important factors in the rapid spread of the disease, but there is nothing in the history of these epidemics to bear out that opinion. The records of careful meteorological observations made in Chicago during the prevalence of the epidemic in 1889-'90 showed the presence in the air of a decided excessive amount of free and albuminous ammonia, with almost entire absence of ozone. Nothing, however, was determined as to any influence this might have had on the rapid evolution of any probable active agent in the etiology of the disease.

The rapid spread of the infection, its almost simultaneous appearance in widely separated localities, and the fact that persons said to be in complete isolation were attacked, naturally suggested that the essential etiologic factor must be capable of rapid development and wide diffusion in the air.

The data to be obtained during so prevalent an epidemic are largely too unreliable for an accurate determination of the methods of transmission, but it is fairly safe to assume that transmission is by human contact or by the secretions from infected people. In those individual cases where contagion seems to have occurred without exposure the mystery usually disappears with the discovery of all the facts.

Lieut. J. J. Keegan, M. C. U. S. N. (Jr. A. M. A., Sept. 28) reports some difficulty in finding the influenza bacillus in the secretions from the mouth and throat or in the blood in these cases. This he explains by the difficulty of isolating the influenza bacillus from mixed cultures, and also by the fact that it probably selects the posterior naso-pharynx rather than the pharynx for its most abundant growth. Smears and cultures from lung punctures and necropsies gave more definite results, for in these the influenza bacillus occurred either in pure or mixed culture in 82.6 per cent of the twenty-three cases studied, and in 31.6 per cent of these in pure cultures.

In a report by A. Hewlett, Surg. U. S. N. R. F., and W. M. Alberty, Asst. Surg. U. S. N. (Jr. A. M. A., Sept. 28) we find the following: "The Pfeiffer influenza bacillus has been isolated from a varying proportion of patients; but many observers have failed to find this organism with any regularity. It is quite possible, indeed, that this organism is not responsible either for the present epidemic or for the pandemic of 1889-1890."

Since the etiology of the epidemic in 1889 was undetermined and there is yet considerable confusion as to the cause of the present epidemic, any attempt to identify them as of the same character must depend upon the symptomatology.

In the literature of the time we find the general symptoms of the disease as it oc-

curred in 1889 as follows: There was no well defined period of incubation and generally no prodromal stage. The onset was remarkably sudden, beginning with chilly sensations often increasing to a chill. There was general depression with pains in the head, back and limbs. Pulse and respiration were variable, both increasing in frequency as the temperature rose. The temperature ranged from 100 to 104.5 F. The skin was dry, urine scanty and high-colored. There was constipation, no appetite, but some thirst. In a large majority of cases there was redness of the conjunctivæ, congestion of the mucous membranes of the nose, pharynx and bronchial tubes, with cough and oppression. During the second day the secretion of mucus was abundant and by the fourth day the nasal discharges and expectorations were mucopurulent. At this time the other symptoms were ameliorated. The duration was from one week to ten days. There were many individual variations from the general clinical picture and there were many and varied complications, the most frequent and most fatal of which was pneumonia. The mortality from uncomplicated influenza was very small, nearly all of the deaths reported being due to pneumonia, phthisis, senility, cerebral affections and other complications.

The clinical reports so far received from the districts already invaded do not differ in any essential feature from those of 1889. In Supplement No. 33 of the Public Health Reports, under date of Sept. 27, 1918, we find the following description of the onset and course of the disease:

"The symptoms in the present pandemic have been an acute onset, often very sudden, with bodily weakness and pains in the head, eyes, back, and elsewhere in the body. Vomiting may be a symptom of onset and dizziness is frequent. Chilly sensations are usual, and the temperature is from 100 to 104 degrees, the pulse remaining comparatively low. Sweating is not infrequent. The appetite is lost, and prostration is marked. Constipation is the rule. Drowsiness and photophobia are common. The conjunctivæ are reddened, and the mucous membrane of the nose, throat, and bronchi often give evidence of inflammation. The general symptoms, however, predominate over the local. Cervical and general lymphadenitis and nystagmus have been reported to be very frequent by certain observers. Charactestically, there is no leucocytosis during the height of the fever, so that a high white count during the first sixty hours is indicative of another disease or of complication. The fever usually lasts from three to five days; but relapses are not uncommon, and complications, particularly pulmonary, are to be feared. The death rate is usually given as extremely low; but in the latter periods of an outbreak an increased number of deaths, presumably due to complications, has been reported in Spain and in the United States. Besides bronchitis and pneumonia, inflammation of the middle ear and cardiac weakness may follow the disease."

From observation of cases that developed in the hospital staff, Keegan fixes the incubation period at from one to two days. He did not observe coryza or sore throat during the early period. Hewlett and Alberty, however, found irritation in the upper respiratory tract with dry cough and soreness of the throat in two-thirds of their cases.

During the epidemic of 1889, or during the latter part of the epidemic period, there were a considerable number of cases in which gastro-intestinal symptoms predominated, and another considerable number in which the nervous system seemed to be most prominently involved.

Extreme cardiac weakness is one of the conditions prominently mentioned in connection with this epidemic; and it was also, in the earlier epidemic, one of the very important symptoms, leading to a long and tedious convalescence and sometimes to a permanent impairment of health. It undoubtedly was a significant factor in the high mortality from pneumonia.

In the epidemic of 1889, quinine was regarded by a large majority of the writ-

ers as nearest to a specific. It was used as a prophylactic and a curative agent. It is unnecessary to say that it was far from a specific, but it seemed to have as much effect upon the duration of the disease as most of the remedies used. In the painful conditions antipyrine and phenacetine were commonly prescribed, but many writers ascribed the depression and cardiac weakness to the too liberal use of these drugs. A prescription recommended by Baccelli was as follows:

℞ Quin. salicyl. 3 grains
Phenacetine 3 grains
Camphor ⅓ grain M.

This was to be given six times in twenty-four hours. Stimulants were regarded as an essential part of the treatment in the cases where depression was marked, and in the pneumonic cases.

As to the treatment in the present epidemic, very little has been reported. There seems to be a general impression that acetylsalicylic acid may be of benefit, but beyond that symptomatic treatment is advised.

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The V. M. S. C.

The real loyal men of this country are not those who sit up nights to devise plans for their own aggrandizement, nor those who are losing sleep in worrying over the honor or credit some other fellow may get out of the war; but the men who are quietly and unostentatiously performing to the best of their ability the duties assigned to them. They care nothing about the pedigree, the social history, or the political ambitions of the men who give the orders, if they have the authority. All they care to know is how, when and where they can be of service.

Such at least are the men in Kansas who, without hesitation, signed the applications for membership in the Volunteer Medical Service Corps. The President's letter of approval indicated that he believed that it would be of some assistance, and that was sufficient.

We do not know what the plans of the organizers of the association are nor how they are to be carried out. Although the developments up to this time do not seem to justify the trouble and expense, we can see great possibilities in such an organization, under a wise and judicious administration of its affairs.

We have reason to believe that a large number of the physicians of Kansas signed applications, but we know of no one having been admitted to membership — yet. The only indication that any members are recognized in the state was the announcement some days ago of the selection of certain men for special duties in connection with the epidemic.

This is no time for us to grow hysterical over the possibility that the officers of this may usurp the prerogatives of the officers of some other organization. Those are matters in which the physicians of Kansas have no voice in times of peace, and certainly not matters about which we should concern ourselves in time of war. If, as seems to be implied by certain criticisms, this organization is only intended for the aggrandizement of some of the men occupying semi-authoritative positions, or if it is intended to interfere with the proper functions of any other organization or with the regularly constituted health authorities, then the keenest disappointment will be felt by those who have permitted themselves to imagine that the medical profession could be used to further such motives. On the other hand, if this organization should prove to be of material benefit to the government or to any of the auxiliary bodies, then the psysicians who have given their pledges will have the satisfaction of knowing that they have unhesitatingly showed their willingness to respond when their help is needed.

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Deaths.

Emerson K. Kellenberger, Yates Center, Kansas; Medical College of Ohio, Cincinnati, Ohio, 1871; aged 68; a Fellow of the American Medical Association and president of the Woodson County Medical Society in 1914; for twenty years local surgeon for the Missouri Pacific Railroad

Company; for two years coroner of Franklin County, and secretary of the first board of medical examiners of his judicial district; died at his home, September 11, from cerebral hemorrhage.

Dr. W. J. Mayo said: "One of the typical features of splenic anemia is the occurrence of hemorrhage from the stomach. Possibly seventy-five per cent of all the severe hemorrhages from the stomach do not have their origin, as is so frequently thought, in peptic ulcer, but arise from some unknown gastrotoxic condition."

We have spent over $120,000,000 just for staple supplies for our army, such as flour, bacon, rice, etc. Every subscriber to the Liberty Loan bonds helps feed our soldiers.

BOOKS.

Surgical Treatment—Volume 1.

A practical treatise on the therapy of surgical diseases for the use of practitioners and students of surgery. By James Peter Warbasse, M.D., formerly attending surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo columes, and separate desk index volume. Volume 1 contains 947 pages with 699 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Per set (three volumes and the index volume), cloth, $30 per set.

We have just received the first volume of Warbasse's Surgical Treatment. In this volume the author has discussed the following subjects: General Principles of Surgical Treatment; Asepsis and Antisepsis; Surgical Materials, Their Preparation and Sterilization; Anesthesia and Anesthetics; Wounds and Operations; Inflammations; Surgical Fevers and Infections; Fistula and Sinuses; Ulcerations and Gangrene; Nutritive Disturbances; Tumors; Blood and Blood Vessels; Lymphatic System; Diseases of Bones; Fractures; Dislocations; Diseases of Joints; Operations on Bones and Joints; Muscles, Tendons, Fascia and Bursæ; Skin and its Appendages; Nerves.

The technique is well illustrated and described in detail and the author has included in the text only such material as will be useful and instructive.

Military Hygiene and Sanitation.

By Frank R. Keefer, M.D., Colonel, Medical Corps, United States Army; formerly professor of military hygiene, United States Military Academy, West Point. Second edition, reset. 12-mo of 340 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $1.75 net.

This was originally prepared as a textbook for the cadets at the U. S. Military Academy at West Point. It seems to be well adapted to the needs of medical officers of the army and particularly those in the training camps.

A very instructive chapter on physical training was supplied by Capt. H. J. Koehler, U. S. A.

While prepared particularly for those in charge of military camps, there is much in this book that will be adaptable to the needs of those in civil life.

Gynecology.

By William P. Graves, M.D., professor of gynecology at Harvard Medical School. Second edition, thoroughly revised. Octavo volume of 883 pages with 490 original illustrations, 100 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $7.75 net.

The second edition of this work shows a considerable revision of the text and some very important new material has been added. The author has rewritten the chapter on the Relationship of Gynecology to the Internal Secretions and has added to the discussion of ovarian organotherapy, ovarian transplantation, the radium treatment of cancer and in nonmalignant diseases. A new section has been added dealing with the relationship of gynecology to the sex impulse.

The work is excellently illustrated and in this edition many new cuts are used.

The Orthopedic Treatment of Gunshot Injuries.

By Leo Mayer, M.D., instructor in orthopedic surgery, New York Postgraduate medical School and Hospital, with an introduction by Col. E. G. Brackett, M.C.N.A., director of military orthopedic surgery. 12-mo of 250 pages, with 184 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.50 net.

This, like a good many of the recent publications, is prepared with special reference to the requirements of war surgery. The orthopedic treatment of war injuries is something that should stimulate the inventive genius of our American surgeons. There is much room for improvement and a book like this, while showing us the construction and application of the various appliances now in use, gives us just an idea of how great the need for improvement is.

The author shows how a proper fixation of an injured part may be accomplished in the field and also how best to restore motion in the ultimate treatment of the case. Several extension appliances and artificial limbs are described.

Can the Young Physician Catch Up?

Dear Editor: I read in our valued Journal, September issue, "Can the Old Physician Come Back," and the writer says most physicians who have practiced medicine for from twenty to thirty years begin to slow down. They accomplish less work, they are less thorough and systematic in their examinations—depending more upon intuition or observation, perhaps. And are prone to follow along older lines of treatment." I want to remonstrate against this unthoughted foolishness. Now we all love the young physician, and all of us have hopes that some day we will be able to say he is a well rounded up man, and a physician who will be of real benefit to the community he may reside in. But when you say the old physicians accomplish less work and are less thorough in their examinations, this does not agree with my experience in my locality or with the physicians of the county in which I reside. I will admit the young man may burn up the road and use more gasoline and will not consume as much time in examining the patient; but how about the patient, if the poor fellow is really sick? Wouldn't it be better to take a little time and make a more thorough examination and know what is the matter, which the old physician will most assuredly do.

"They study less"—no, when the old physician is not busy with patients he is studying, he is reading medicine; how about the young physician when he is not busy with patients?

They say the old doctor will need a new library. Not in our county, the middle-aged and older doctors have the libraries.

Some time ago I was talking with a representative of one of the large medical book houses, and he told me the middle-aged and old doctors bought the books. He said the young doctor was a very poor book buyer.

But let us dwell together in unity, there is a place for the old physician as well as the young. And when the old professor signs the young man's diploma, is his life's work complete? No; he is just getting ready to enter the race, and when he comes home let us encourage him to run faster and faster; it will take him about ten years to catch up with the band wagon, where he can hear the sweet strains of music and see the real great things in his professional work and the great good he may be able to accomplish in the world.

No; do not ask the old doctor to come back, but encourage the young doctor to catch up. E. G. M., Kansas.

OFFICIAL ANNOUNCEMENT.

The Volunteer Medical Service Corps.—An Appeal to Executive Committees and County Representatives of the Volunteer Medical Service Corps, and State Committees of the Council of National Defense.

No official or committeemen representing the Volunteer Medical Service Corps or the General Medical Board of the Council of National Defense, is now authorized or has been authorized to favor any organized or unorganized method of coercion in inducing members of the medical profession to join the Medical Corps of the Army or Navy, or the Volunteer Medical Service Corps. Our committeemen are especially urged against favoring any movement that would threaten to impair a medical man's standing in his local, state or national society because he refused to enroll in the Army or Navy, or the Volunteer Medical Service Corps.

It must be made clear that the Volunteer Medical Service Corps is a volunteer organization which has for its object the enrollment and classification of the profession. Its members are entitled to wear an insignia which will clearly indicate that they have offered their services to the Government, when such services are needed. Patriotism cannot be created by coercion. It also must be made clear that the Volunteer Medical Service Corps has for its primary object furnishing its classification to the Army, the Navy, the Public Health Service, the Red Cross and Provost Marshal, as well as to civilian institutions and communities, as a guide in providing for their needs to the best advantage.

The object of the Corps is not to disturb any medical man in the performance of

any duty to which he has been assigned by any governmental agency either for service at the front or at home.

EDWARD P. DAVIS, President,
Volunteer Medical Service Corps.
FRANKLIN MARTIN, Chairman,
General Medical Board, Council of National Defense.

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To the Army and Navy.

The following physicians of Kansas have been reported as having accepted commissions in the army and navy since September 1:

R. S. Pickler, Beloit
A. W. Lovene, Burdick
S. H. Kellam, Cherryvale
W. S. Prout, Concordia
W. H. Young, Fredonia
B. B. Mason, Grenola
A. J. Lind, Kansas City
J. W. Risdon, Leavenworth
D. R. Sterrett, Leavenw'th
B. H. Jordan, Medicine Lodge
R. A. Taylor, Meriden
C. L. Randall, Neodesha
F. A. Trump, Ottawa
H. A. Alexander, Topeka
H. W. Gootee, Topeka
W. H. Weidling, Topeka—Navy
E. M. Ireland, Coldwater
F. A. Eckdall, Emporia
H. P. Knowles, Sterling
G. H. Allen, Topeka
A. H. Nossaman, Whitewater
M. F. Russell, Great Bend
G. C. Mahaffey, Ottawa
H. A. Vincent, Perth
W. V. Hartman, Pittsburg
E. G. Padfield, Salina
G. C. Funk, Smith Center
W. H. Robinson, Eudora
E. E. Haynes, Madison
E. F. Clark, Mayfield
R. M. Tinney, Norton
F. A. Carmichael, Osawatomie
O. R. Brittain, Salina
J. H. O'Connell, Topeka

Orders to officers of the Medical Corps:

To Camp Dodge, Iowa—Lieut. H. A. Alexander, Topeka.

To Camp McArthur, Texas—Capt. O. J. Corbett, Emporia; Capt. O. M. Owensby, Pittsburg; Lieut. D. L. Heidrick, Welda.

To Camp Pike, Ark.—Capt. J. A. McLaughlin, Greensburg.

To Fort Oglethorpe, Ga.—Capt. E. D. Ebright, Wichita; Lieut. C. O. Davison, Garden City; Lieut. G. K. Haughey, Wakeeney.

To Fort Riley—Capt. F. J. Walker, Wichita; Capt. P. W. Robinson, Osawatomie; Lieut. H. M. Makins, Abilene; Lieut. J. W. West, Narka; Lieut. G. H. Allen, Topeka; Lieut. W. R. Brady, Parsons; Capt. D. I. Maggard, Wichita.

To Middletown, Pa.—Lieut J. B. Edwards, Garden City.

To Jackson Barracks, La.—Lieut. J. O. Williams, Emporia.

To Report to Commanding General, Central Dept.—Capt. W. B. Coe, Waterville.

To Cambridge, Mass.—Lieut. L. G. Eastman, Auburndale.

To Camp Bowie, Texas—Lieut. R. S. Pickler, Beloit.

To Fort Sam Houston—Lieut. H. S. Kellam, Cherryvale.

To Camp Custer—Capt. L. C. Lewis, Kansas City.

To Camp Gordon—Lieut. E. D. Rodda, Armour.

To Rochester, Minn., Mayo Clinic—Capt. C. J. Magee, Leavenworth

To Walter Reed Hospital, D. C.—Capt. J. W. Faust, Kansas City.

To Beauregard, La.—Lieut. L. D. Mabie, Kansas City; Lieut. A. L. Knisely, Liberal; Capt. F. H. Slayton, Wichita.

To Camp Grant, Ill.—Capt. F. A. Carmichael, Osawatomie.

To Camp Logan, Texas—Capt. G. R. Gage, Hutchinson.

To Camp Wheeler, Ga.—Lieut. W. B. Burr, Longton; Lieut. J. H. Hansen, Elkhart.

To Walter Reed Hospital, D. C.—Lieut. W. L. Butler, Stafford.

Special War Program Arranged for the Meeting of the Medical Association of the Southwest, to be Held in Dallas, Texas, October 15, 16 and 17, 1918.

Medical matters pertaining to the war will feature this program, which promises to be the best of its kind yet offered in the South. The membership of this association is composed of physicians from the five states of Missouri, Kansas, Oklahoma, Arkansas and Texas and a large attendance is expected.

One evening's meeting will be given over to entertainment by the Dallas profession. On another evening will be shown the celebrated Government war film entitled "Fit to Fight." This will prove to be especially interesting, since a lecturer sent from Washington will speak upon the subject as the pictures are thrown upon the screen. A third evening will be occupied by Dr. Charles A. R. Campbell of San Antonio, Texas, who will deliver a lantern slide lecture, and show how the bat can be cultivated in large numbers, thereby destroying mosquitoes, and through their destruction malarial fever can be absolutely stamped out.

Every department in Washington in any manner interested in medical matters will be represented, as they have all agreed to furnish official contributions to the Dallas meeting of the association. Surgeon General Braisted of the Navy has promised to send a representative from his department, who will represent and speak for the navy medically, upon the occasion. Surgeon General Blue of the Public Health Service has promised a speaker to handle some topic dealing with the venereal disease problem as it concerns the soldier. Lieutenant Colonel Harry Mock, president of the National Association of Industrial Physicians and Surgeons, will treat some subject in relation to the work of reconstruction, as planned to be operated by the Government in the interest of its returned fighting men. The American Red Cross will be represented by Judge Quentin D. Corley, who will outline the work to be undertaken by this splendid organization in behalf of returned soldiers and sailors following the war, and illustrate same with slides. The Pure Food Department at Washington will furnish a prominent speaker, whose name will be announced later. Dr. Franklin H. Martin of the Council of National Medical Defense agreed to designate a speaker to represent his department. On account of

the absence of Surgeon General Gorgas in France, someone connected with his department is promised us, who will be present for the convention, with a timely contribution. A man of national fame will speak upon the entry of Spanish influenza to the United States and how to fight and combat it.

President Vinson of the University of Texas, or Dr. T. W. Riker of the School of History will address the convention upon the subject of "What the U. S. Government is Doing in an Educational Way for the Young Men of the Country Under the Draft Age."

A number of other prominent speakers of national reputation will be announced in a complete program of the meeting, to be made public later.

A PARTIAL PROGRAM OF THE SECTIONS ON SURGERY AND MEDICINE.

Dr. L. F. Purifoy, Eldorado, Ark., "An Unusual Case of Abdominal Pregnancy."

Dr. C. S. Holt, Fort Smith, Ark. (subject not given).

Dr. A. C. Scott, Temple, Texas, "Toxic Goiter."

Dr. M. E. Stout, Capt. M.R.C., Ft. Sam Houston, Texas, "Hernia."

Dr. Charles H. Harris, Ft. Worth, Texas, "What is the Present Day Status of the Appendix?"

Dr. John A. Lightfoot, Texarkana, Ark., "Herniotomy."

Dr. J. E. Gilcreest, Gainesville, Texas (subject to be announced).

Dr. A. D. Updegraff, Wichita, Kan., "A Plea for the Closure of Cleft Palate Before Three Months of Age."

Dr. Leo A. Sutter, Wichita, Kan., "Intestinal Obstruction Viewed from Different Angles."

Dr. A. A. West, Guthrie, Okla., "Surgical Indications in Gall Bladder Affections."

Dr. D. C. Homan, Oglesby, Texas, "Puerperal Fever."

The Dallas medical fraternity have taken active steps to arrange special clinics which will be of interest to the members of the Association, and suitable entertainment of the guests will be provided, in keeping with the occasion. A complete program will be mailed soon to the membership. Plans are being rapidly carried out to make the convention a thing to be remembered in medical history and association affairs, as a special war meeting. A large attendance is expected. In every case where possible physician members of the association should begin to lay their plans to be present, if possible, for the three days' session.

Exhibitors are invited to be present, and ample arrangements have been prepared for their displays. Any one desiring information concerning the meeting, either as regards space or other matters, is invited to address Dr. M. M. Smith, Acting Secretary and Chairman of the Arrangements Committee, at Box 207, Dallas, Texas.

Officers of the Medical Association of the Southwest: President, Dr. E. H. Martin, Hot Springs, Ark. Vice Presidents—Dr. C. Lester Hall, Kansas City, Mo.; Dr. J. N. Bonham, Hobart, Okla.; Dr. E. F. Day, Arkansas City, Kan.; Dr. M. M. Smith, Dallas, Texas. Secretary-Treasurer—Dr. F. H. Clark, El Reno, Okla. (in the service).

———R———

Volunteer Medical Service Corps of the United States.

Authorized by the Council of National Defense. Approved by the President of the United States.

INFORMATION.

1. What is the Volunteer Medical Service Corps?

The Volunteer Medical Service Corps is an organization which provides means for obtaining quickly men and women for any military or civil medical service required in the war emergency. It furnishes recommendations and necessary credentials to assure the best medical service, both military and civil.

2. How should application for membership be made?

Upon request to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C., application blanks and circulars of information will be sent. When received, the application form should be filled out completely, in accordance with instructions contained in the circular of information. The application should then be mailed to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

3. What is to be gained by the creation of this organization?

Placing on record all medical men and women in the United States; aiding Army, Navy, Public Health Service, Provost Marshal General's office and the American Red Cross in supplying war medical needs; providing the best civilian medical service possible; giving recognition to all who record themselves either in Army, Navy, Public Health Service, Provost Marshal

General's office, Red Cross activities or civilian service.

4. What is meant by classification?

It is the record of information furnished by the individual physician so that when the need arises, he may be requested to perform service that will be mutually advantageous to the individual and the service to which he may be assigned.

5. Who are eligible?

Every legally qualified physician holding the degree of Doctor of Medicine from a legally chartered medical school without reference to age or physical disability is eligible for membership in the Volunteer Medical Service Corps provided he or she is not already commissioned in the Government service.

6. How is eligibility to the Corps determined?

Upon information obtained from application blanks, three personal references and the executive committee of the state in which the applicant resides. Based upon the information thus secured, the Central Governing Board will finally pass upon applications.

7. Does membership in the Corps carry with it rank and pay?

This Corps is not authorized to bestow rank. Arrangements for compensation shall be made between a member requested to perform a specific duty and the agency requesting service. The matter of compensation and place of service whether with or without rank must be determined at the time said request is made. When a member of the Corps accepts service in the Medical Reserve Corps of the Army, the Naval Reserve Force, the United States Public Health Service, the American Red Cross or any governmental department, he or she will be accorded the rank and pay incident to the service in the department in which he or she has enrolled.

8. Will any member of this Corps be ordered to active duty?

No member will be ordered to render any service. Requests to perform specific duties according to qualifications and availability under the classification of the Volunteer Medical Service Corps may be made from time to time as emergencies arise.

9. What will be the probable character of service members will be requested to render?

(*a*) Medical Reserve Corps.

(*b*) Naval Reserve Force.

(*c*) United States Public Health Service.

(*d*) American Red Cross.

(*e*) Local and medical advisory boards.

(*f*) State and local health departments.

(*g*) Medical schools and hospitals.

(*h*) Industrial plants.

(*i*) Civil communities: Caring for civil communities stripped of medical attention; caring for practices of physicians in military service; reclamation of registrants rejected for physical unfitness; services to needy families and dependents of enlisted men.

(*j*) Miscellaneous service.

10. If members of the Corps are recommended for active military or naval service, in what order will they be recommended?

(*a*) Physicians under 55 years of age without dependents and without physical disabilities which are disqualifying will first be recommended. Following this group, physicians under 55 years of age without obvious physical disabilities which are disqualifying and with not more than one dependent in addition to self (Class I of the Volunteer Medical Service Corps) will be among the first to be recommended for actual war service. Any physician under 55 years of age who is without an obvious physical disability which is disqualifying and whose dependents have an income sufficient for the support of dependents other than that derived from the practice of his profession, may be recommended to enroll in the Medical Reserve Corps of the Army, the Naval Reserve Force or the United States Public Health Service when in the opinion of the respective Surgeons General his services are needed.

(*b*) Physicians under 55 years of age without obvious physical disabilities which are disqualifying and with not more than three dependents in addition to self (Class II of the Volunteer Medical Service Corps) will be the next group to be recommended to apply for active military or naval service.

(*c*) The next group recommended to enroll for active duty with the Army, Navy or Public Health Service (Class III) will be physicians under 50 years of age who are without obvious physical disabilities which are disqualifying and with more than three dependents in addition to self.

11. What are the exceptions in these groups?

The exceptions in the above groups of physicians are as follows:

(*a*) Those essential to communities.

(*b*) Those essential to medical schools and hospitals.

(*c*) Those essential to health departments.

(*d*) Those essential to industries.

(*e*) Those essential to local and medical advisory boards.

12. How will exceptions to these groups be determined?

(*a*) Essential to communities: Essential community need will be determined by the Central Governing Board on recommendation of representatives of the Central Governing Board appointed by the Board to make a survey of local conditions.

(*b*) Essential to institutions: Essential institutional need will be established after conference between representatives of the Central Governing Board of the Volunteer Medical Service Corps and representatives appointed by the governing bodies of the institutions concerned.

(*c*) Essential to health departments: Essential health department needs will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of health departments.

(*d*) Essential to industries: Essential industrial need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and accredited representatives of industries involved.

(*e*) Essential to local and medical advisory boards: Essential local and medical advisory board needs will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of the Provost Marshal General's office.

13. When will phsicians who are not classified for actual military or naval service be requested to perform service?

When the emergency arises the following may be requested to perform duties in accordance with their qualifications and expressed merits as indicated by the information contained on their application blanks:

(*a*) Physicians over 55 years of age.

(*b*) Physicians with obvious physical disabilities which are disqualifying.

(*c*) Those rejected for all Government service because of physical disability.

14. What are some of the duties that this last group of physicians ineligible for active military service may be requested to perform?

(*a*) Deducting those members of the medical profession who will eventually be in active military, naval or public health service, fully 75 per cent of the remainder will be encouraged to continue at their home duties.

(*b*) Some of these may be called upon to supplement their private practices by performing part time service to meet community needs hitherto performed by men called to active duty.

(*c*) Twenty-five per cent of those not actually engaged in war service (possibly 20,000 in number) who are now engaged in home duties but who have agreed to do work of any kind, anywhere, upon request of the Central Governing Board, will as the emergency arises be recommended for duty in the following places: 1. Local and medical advisory boards. 2. Medical schools and hospitals. 3. Industrial plants. 4. Health departments. 5. Communities lacking medical service.

15. How does enrollment in this Corps differ from actual conscription?

The Volunteer Medical Service Corps is exactly what its name indicates. It is a gentleman's agreement on the part of the civilian doctors of the United States who have not yet been commissioned in the Army or Navy or enrolled in the Public Health Service, or in the service of the Provost Marshal General, and a representative board consisting of government officials associated with lay members of the profession in which the civilian physicians agree to offer their services to the Government if requested to do so by the Central Governing Board.

16. In what way can this Corps aid the Government?

By recording all physicians who are not yet in service and classifying them so as to utilize the talents and facilities of individuals to the best advantage and inflict as little hardship on the individual as possible, in accordance with the letter from the President of the United States authorizing the Corps "to supply the needs of the Army, Navy and Public Health Service * * * aiding in the important work of the Provost Marshal General's office and Red Cross * * * and the problems of the health of the civilian communities of the United States." It provides a method by which every physician not in uniform will be entitled to wear an insignia which indicates his willingness to serve his Government. It furnishes a method by which the medical needs of the nation may be provided for through a representative board of physicians who know the needs

of the Army, Navy, Public Health Service, Red Cross and civil communities.

17. To what extent must provision be made for essential civilian and industrial medical needs?

A large percentage of the physicians of the country will be required to care for their respective home communities and to meet civilian health needs. This percentage of necessity will be expected to maintain their home status and continue their professional work.

18. Will enrollment in the Volunteer Medical Service Corps excuse a physician in the draft age from registration under the Selective Service Law or from being classified therein?

Positively not.

19. Why then enroll in the Volunteer Medical Service Corps if it does not supplant the draft?

(*a*) Under the Selective Service Law individuals in the draft age are registered and inducted into the service as privates. The Volunteer Medical Service Corps enrolls and classifies individuals as prospective commissioned officers and will when requested assist in establishing the individual's status when he requests transfer from the enlisted forces to the commissioned branches of the service.

(*b*) Enrollment in the Volunteer Medical Service Corps definitely registers the physician as a patriot and provides definite governmental recognition of his willingness to serve.

20. Why should every physician in the United States enroll in the Volunteer Medical Service Corps?

(*a*) The unsurpassed record of volunteer enrollment for actual service on the part of the medical profession must be maintained.

(*b*) The Army and Navy must not be hampered for a moment for lack of doctors to care for the sick and wounded boys fighting our battles at the front.

(*c*) The public health must be conserved.

(*d*) The medical needs of the Provost Marshal General must be adequately met.

(*e*) The great industries furnishing materials of war employing thousands of patriotic workers, must have medical service.

(*f*) The home folks, the old and the young wearily waiting over here, must have doctors.

(*g*) Recording, classifying, and careful distribution and full utilization of our entire profession of medicine will enable us to instantly supply all demands, and our utmost resources will then be available to aid in establishing a permanent peace that will forever make this world a safe place in which women and children may live.

R

National Birth Control League.—A Reply

Editor Journal of the Kansas Medical Society.

Dear Sir: Your interesting editorial about our questionnaire on birth control has been called to my attention. I trust you will have space in your magazine for some comment on certain points.

We are glad to note the good will expressed in your statement that you "do not question the altruism of those engaged in this movement, nor doubt their philanthropic motives." Our motives, however, are not exactly in the philanthropic class. Philanthropy is usually only palliative, while our aim is more a fundamental social cure for human suffering, by making legal the knowledge by which people can help themselves so as to avoid much need for philanthropy.

Next you wonder at our "apparent oversight of the moral status of the legislation now in force, and of the moral and economic elements which led to its adoption." I assure you we have not overlooked this question. Indeed we have most carefully scrutinized it and the more we investigate, the more evident it becomes that the present laws tend to produce immoral instead of moral results. The laws prohibit contraceptive knowledge along with abortion and things obscene, with no distinction between them. This alone has a tendency to poison people's minds with the highly immoral assumption that the subject itself is dirty. Your inference is that morals can result from ignorance. Since when has that been true? Even assuming that contraception might be wrong, the individual who does not know how to sin is surely not so strong a character as one who, knowing, refrains. But a better and more pragmatic answer to your inference that our present laws induce morality is that in the countries having easy and legal access to contraceptive information there is a state of public morals far better than ours. The proof of the pudding is the eating.

New Zealand for instance, which has no ban on birth control information, has about the highest ratio of increase of population in the world, the lowest death rate and infant death rate on record, the most wonderful chain of maternity and baby hos-

pitals, and general social welfare laws which are acknowledged to be in the very van of progress. Does this sound like moral degeneracy? Physical and moral well being are so closely interrelated that a conclusion that New Zealand is a country in which morality is waning is impossible.

You state that you "have no means at hand for determining the accuracy" of our statement that birth control information uniformly results in a healthier, happier nation and a population which is increasing without waste. The evidence is easily secured, and as a start in acquiring it, we are sending you, with the compliments of the League, a copy of "The Small Family System," by Dr. Charles V. Drysdale of London, the well known student of this subject. In it you will find the birth and death statistics of many countries and most convincing data proving our case. We suggest that a comprehensive digest of this book would be admirable in your magazine. Again instancing New Zealand, it has a baby death rate of only fifty per thousand, while the United States has sixty big cities with a rate of over one hundred per thousand.

Next you take up our statement that the best modern scientific research has proved that wisely chosen contraceptive methods are not injurious to health. You say that reports of such research have not been widely published. True, and they will not be till the subject is taught in the medical schools and it is legal to publish the data. You further state that you doubt if medical men in general practice would "agree that the contraceptive methods in most common use are not injurious," and that "most every one has had cases in which the injury from such methods was very pronounced and unmistakable." There has been much more research abroad than here, and specific information about it may be had from men like Dr. Drysdale and Dr. J. Rutgers, head of the Neo-Malthusian League of Holland. But there is an imposing array of medical endorsement in our own country. The opinions of physicians like the following surely count: Dr. Abraham Jacobi, ex-president of the American Medical Association; Dr. L. Emmet Holt, the baby specialist; Dr. H. H. Goddard, the expert on the feeble-minded; Dr. John O. Polak, the gynecologist; Dr. Bass of Tulane University, La.; Dr. Rachel Yarros of Chicago, and many more whose names can easily be given if you wish.

We agree with you that much of the current contraceptive information illegally circulated is poor and even harmful. Like you, we have much evidence of the damage it does. That is one of the most urgent reasons for changing the laws so that the best possible scientific knowledge may be made available. We want to be free to publish a pamphlet of such information, prepared by a special committee of nationally known physicians, giving the very finest, safest information which the world affords.

You admit that contraception is now practiced by hundreds of thousands of the well to do, but you doubt if the poor are left in ignorance of the knowledge which the rich apparently get. You assert that the poor "are quite familiar with the methods used by the well to do, but are either more considerate of their health and happiness or more indifferent to the inconveniences of frequently recurring pregnancy." This we are certain is not the case. Most of the requests which come to us for information are from the poor.

You note that our arguments in the questionnaire omitted the effects on "moral and social life." As this questionnaire was sent only to health authorities and with reference primarily to individual and public health, the questions were limited to that. But if you were to read all our publications, you would see that the moral and social side has full attention. And we claim that the world's evidence is that birth control raises, not lowers moral and social standards. (I am sending you specimens of our publications.)

Your last paragraph on "virtue" seems to imply that sexual abstinence and "virtue" are synonymous. If that be true, the repeal of the laws forbidding contraceptive knowledge cannot alarm the already "virtuous." They will proceed as before, according to their principles, to live abstinent lives, except at the relatively few times when procreation is intended. So why should the program be opposed, on behalf of that kind of "virtue"? You allude to the unmarried, who "stand in greater awe of a possible inopportune pregnancy and consequent exposure and social ostracism, than of all the laws of God or man," and who therefore are "virtuous" through fear of results. You infer that it is wholesome to keep such people in fear of results and that such "virtue" should be protected by the law. Our claim is that it is high time to face the question of sex morality without fear. If our

young people can only be held to right conduct by fear, whose fault is it that their standards are so low? We elders who have brought them up have a grave responsibility and we should be heartily ashamed of ourselves if we shirk it, and depend upon our vulgar behind-the-times laws to be a substitute for the high idealism which we should teach our youth. Clean, fine, intelligent sex living is the only road to real morality.

The physicians can do more than almost any other class to raise the standard, if they will. We need their help!

Sincerely yours,
MARY WARE DENNETT,
Executive Secretary.

R

Red Cross Fighting Tuberculosis in Italy.

Announcement was made today by the War Council of the American Red Cross of the personnel of the medical unit which will sail for Italy within a few weeks to conduct a health campaign in that country with the stamping out of tuberculosis as its particular objective. The movement has the fullest support of the Italian government, which intends to build permanently on the foundation laid by an educational campaign as complete and thorough as the Red Cross can make it. The sum of $1,100,000 has been appropriated to carry on the work for the last six months of the present year.

The Italian Tuberculosis Unit of the American Red Cross, as the organization will be known, will be under the supervision of Colonel Robert Perkins, Red Cross Commissioner for Italy. It was on the suggestion of Mr. Perkins that the work was undertaken. Soon after his arrival in Italy he became convinced that the Red Cross should broaden the scope of its activities in that country beyond the lines confined to war work and help the Italian government in the fight against the spread of tuberculosis. He communicated this conviction to the War Council with the result that in a little more than six weeks the medical unit has been equipped and is ready to embark on its humane mission.

Included in the personnel of the unit which numbers sixty persons, are many of the country's best known tubercular specialists, as well as physicians who have been very successful in the lines of work which they will be called upon to perform. The director of the unit is Dr. William Charles White of Pittsburgh, recognized as one of the leaders in the fight against tuberculosis in the Middle West. For ten months Dr. White has been director of the Red Cross tuberculosis unit in France. Dr. Robert H. Bishop, Jr., Commissioner of Health of Cleveland, is assistant director of the expedition. Other heads of departments are:

Dr. John H. Lowman, professor of clinical medicine at Western Reserve University, Cleveland, chief of the medical division; Dr. Louis L. Dublin of New York, statistician of the Metropolitan Life Insurance Company, chief of the division of medical statistics; Dr. Richard A. Bolt of Cleveland, connected with the health department of that city, chief of child welfare division; Dr. E. A. Paterson of Cleveland, chief of division of medical inspection of public schools; Dr. Robert G. Paterson of Columbus, Ohio, head of the tuberculosis branch of the state health department, chief of the division of education and organization; Miss Mary S. Gardner, head of the bureau of public health nursing of the American Red Cross, chief of division of public health nursing.

The executive manager of the organization is Lewis D. Bement of Framingham, Mass., and the executive secretary is Miss Bertha M. Laws of Philadelphia. Thirty-five members of the unit will sail for Italy shortly and the others will follow within a month. There will be eighteen nurses in the organization, the headquarters of which will be in Rome.

Ten traveling automobile dispensaries, three completely equipped for dental work and the others for general medical work, and fourteen motion picture machines will be taken along. It has been planned to have the publicity department attached to the unit start out several weeks in advance and awaken public interest in the movement. The motion pictures will follow with a display of health propaganda prepared in story form and then will come the members of the unit to organize the health work in each town.

R

Help Needed.

The local secretary of the U. S. Civil Service Board at Kansas City has sent this office a statement of the urgent needs of the Government in the way of help in carrying on the work of the war. The greatest need at present seems to be for certain mechanics, qualified to do shipbuilding, and for stenographers, typewriters and bookkeepers, and special clerks in the departments at Washington.

The mechanics most needed just now, which can be supplied by this section of

the country, are machinists, blacksmiths and boilermakers. The ship carpenters, coppersmiths and sailmakers, and those of several other allied trades, are furnished mostly from the sections nearer the coast, but of course any who apply here will be accepted. The Kansas City Civil Service office is authorized to approve applications, hire the men and pay their way to the place of employment. This railroad fare is not held out of their wages. The pay is from 72 to 78 cents per hour.

Among the positions of a clerical nature, those requiring a knowledge of stenography and typewriting are calling for the most recruits. Two examinations for stenographers and typewriters are held every week—one on Tuesday at 9 a.m. and one on Saturday at 2 p.m. Applicants from all parts of the country may take these examinations at Kansas City, Missouri. Applications need only be submitted to the examiner on the day of examination, and do not have to be mailed into Washington, as was formerly the case. Examination papers are graded quickly and all who pass are offered immediate appointments. The entrance salary is $1,200, and promotions are rapid.

A great many technical positions are open and may be secured by simply filing an application—no examination being necessary. All such positions, however, are highly technical, and can only be secured by those especially educated and qualified for the work.

Full information may be secured by writing to the Secretary of the Civil Service Board, room 314 Post Office Building, Kansas City, Missouri.

A Broadly Useful Hypnotic and Sedative.

As a hypnotic, Chloretone is indicated in many conditions, such as acute mania, puerperal mania, periodical mania, senile dementia, agitated melancholia, motor excitement of general paresis; insomnia of pain, as in tabes dorsalis, cancer, and trigeminal neuralgia; insomnia of mental strain or worry; insomnia of old age, nervous diseases, etc. It is often effective in these conditions when other drugs have failed.

As a sedative Chloretone is useful in alcoholism, cholera and colic; also in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays the nausea of pregnancy, gastric ulcer and seasickness; the nausea and vomiting of anesthesia, etc.

Chloretone acts upon the central nervous system, but therapeutic doses are said to have little or no effect upon the heart and respiratory center. The hypnotic dose for an adult is from ten to fifteen grains. Good results have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. One large dose the second night rather than two or more smaller doses would seem to be a logical procedure. The administration of Chloretone is not attended with digestive disturbances.

An Appeal to the Doctors and Dentists of the Country.

1. In view of the limited supply of platinum in the country and of the urgent demand for war purposes, it is requested that every doctor and dentist in the country go carefully over his instruments and pick out *every scrap of platinum* that is not absolutely essential to his work. These scraps, however small and in whatever condition, should reach Governmental sources without delay, through one of two channels:

(*a*) They can be given to proper accredited representatives of the Red Cross who will shortly make a canvass for that purpose.

(*b*) They may be sold to the Government through any bank under the supervision of the Federal Reserve Board. Such banks will receive and pay current prices for platinum.

By giving this immediate attention you will definitely aid in the war program.

2. It is recognized that certain dental and surgical instruments requiring platinum are necessary, and from time to time platinum is released for that purpose. It is hoped, however, that every physician and every dentist will use substitutes for platinum for such purposes wherever possible.

3. *You are warned* against giving scrap platinum to anyone who calls at your office without full assurance that that individual is authorized to represent the Red Cross in the matter.

F. F. SIMPSON, M.C.,N.A.,
Chief of Section of Medical Industry.

Health Instructions Through Draft Boards.

Provost Marshal General Crowder recently called attention to a circular of instructions prepared by the United States Public Health Service for registrants declined in the draft because of physical dis-

ability. The circular, copies of which have been placed in all the local draft boards throughout the country, is the result of a recommendation made to General Crowder by Surgeon General Rupert Blue of the U. S. Public Health Service. The Surgeon General points out that in the first draft about one-third of the men examined were rejected for physical disabilities and that hundreds of thousands will be added as a result of the examinations to be made of the new registrants.

"It is highly desirable," said Surgeon General Blue, "that the men found to be disqualified for military service by the examining physicians of the local draft boards should receive definite instructions as to the meaning of their disabilities and that a strong appeal be made to them to correct these disabilities as far as possible. But the object of this measure is not only to reclaim men for military service or for such service as they can perform, but to lessen the burden of illness and disability among those engaged in essential industrial work. It is hoped that the instruction in this circular, which is really a primer of the physical defects of the nation, will reach far beyond the draft board and be utilized by all agencies interested in improving the public health to instruct the people with regard to their physical deficiencies and the ways and means by which they can be remedied."

R

Tubercle Bacilli.

H. J. Corper, Chicago (Journal A. M. A., May 4, 1918), has been investigating the problem of the relative virulence of tubercle bacilli in the sputum of consumptives. The earlier literature, he finds, is indecisive as to this question. Certain considerations must be kept in mind, however. Fraenkel and Baumann found guinea-pigs alone available for determining the pathogenic properties of tubercle bacilli, and Marmorek calls attention to the fact that in this study of the infectious power of the bacilli it is necessary to note the distribution of the anatomic lesions, and only in a very insignificant manner consider the duration of life. Corper, therefore, began his studies with the use of rabbits and guinea-pigs, the former was used merely to determine the type of bacillus, or whether human or bovine. The purpose of Corper's investigation was not to determine the smallest number of the germs necessary for causing infection, but to determine the range of virulence of tubercle bacilli isolated from the sputum of open consumptives. It was deemed satisfactory to use the dilution method, after weighing the amounts of bacilli used, and to count the bacilli by staining them after carefully making the various dilutions. This method had the advantage of not exposing them to light. In speaking of virulence, one must remember that this term is merely relative. An organism may be highly virulent for one type of animal and yet be avirulent for another. Thus, for example, the human tubercle bacillus is non-virulent for the rabbit. This means in reasonable doses and within reasonable time. It is also advisable to remember that infection rather than a single, exposure, and that in man is due to repeated or prolonged, death in tuberculosis is due generally to accident. This is especially significant in ruling out duration of life as a factor in determining the virulence of the tubercle bacillus. The tubercle bacilli used in Corper's studies were directly cultivated from the sputum by Petroff's method, and were usually from one to two months old. "No appreciable difference was noted in the virulence of the bacilli taken from the same culture at from one to three months. For the tests, an emulsion was made equivalent to 1 mg. of the moist culture in 1 c.c. of physiologic sodium chlorid solution, so that on examination the bacilli were found at most only in lumps of from two to ten. The emulsion was then diluted with physiologic sodium chlorid solution until 1 c.c. contained 0.1 mg., 0.001, 0.000,-0001 and 0.000,000,01 mg. These amounts were then injected into four male guinea-pigs, all of the same size and weighing from 500 to 600 gm. At the end of two months after infection, the guinea-pigs were examined for anatomatic involvement and graded from — to ++++, depending on the extent of the involvement. The number of bacilli found per milligram of moist culture was from 5 to 6 billions, so that the 0.000,000,01 mg. dilution con-

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Very truly yours,

S. S. GLASSCOCK, M.D., Res. Supt.
A. L. LUDWICK, A.M., M.D., Asst. Supt.
EDITH GLASSCOCK, B.S.
Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

tained from fifty to sixty tubercle bacilli." Eighty-two cultures were thus examined, and all but two of these produced tuberculosis in the guinea-pig within two months after a subcutaneous injection of 0.000,001 mg. of the moist culture. Other details of the method used are given, and Corper concludes that doses as small as 0.000,001 mg. could produce tuberculous infection in guinea-pigs, also that the range of variation of virulence is very small. These findings point to the dangers of droplet infection, and it seems justifiable to conclude that the tubercle bacilli found in the sputum of consumptive patients varies slightly and are practically all pathogenic, and that a dose as small as 0.000,001 mg. might infect a child, as may be deduced from Webb and Gilbert's observations. These experiments also seem to lay special emphasis on the importance of sputum examination in military test requirements.

———R———

Program of Kansas Hospital Association, Newton, Kansas, October 11.

Meeting called to order 9 A.M. and 2 P.M.

The Ethics and Economics of the Healing Art — Dr. G. W. Jones, Lawrence, Kansas.

Hospitals: Religious, Municipal and Private—Dr. J. T. Axtell, Newton, Kansas.

Nurses' Training Courses—Round table discussion led by Sister Mary Helena, Salina, Kansas.

Hospital Records—Dr. A. E. Hertzler, Halstead, Kansas.

A Balanced Ration — Miss Francis Brown, Manhattan, Kansas.

Hospital Standardization — Dr. C. H. Shutt, St. Louis, Mo.

———R———

Doan's Kidney Pills.

A testimonial for Doan's Kidney Pills by Mr. Ford appeared in the Kankakee Daily Republican, nearly three months after he was dead and buried. The advertisement containing the testimonial said: "Follow Kankakee people's example, use Doan's Kidney Pills."—Journal A. M. A., July 13, 1918, p. 140.

———R———

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(1941)

Mobilization of Women Physicians for Anesthetic Service.

Every effort is being made to keep war surgery at top-notch efficiency and to provide life-saving anesthesia for every wounded American doughboy, both at the front and in the hospitals in Blighty.

In this connection the following telegram is self-explanatory:

"Washington, D. C., Sept. 18.

"Dr. F. H. McMechan, Avon Lake, Ohio.

"Proceed at once to secure qualified women physician anesthetists under 45 years of age, of mental poise, as well as young women graduates, who are competent for such service. (Signed)

DR. FRANKLIN MARTIN

Per DR. EMMA WHEAT GILLMORE

Chairman Woman Physicians' Committee, Council National Defense — Medical Section."

Those women physicians who are qualified for anesthetic service or who are competent to be intensively trained are requested, at once, to get in touch with Dr. F. H. McMechan, Secretary Interstate Anesthetists, American Anesthetists, Avon Lake, Ohio.

The People and War Taxes.

More than $3,500,000,000 has been collected in internal revenue taxes, including income and excess-profits taxes, for the fiscal year. This exceeds by over $100,000,000 the estimates made a few months ago, and by over $200,000,000 the estimates made a year ago when the revenue measures were passed by Congress.

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, NOVEMBER, 1918 No. 11

The Clinical Value of the Wassermann Reaction and Other Laboratory Tests in the Diagnosis of Syphilis.

H. M. CONNER, M.D., Rochester, Minn.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

I come to you tonight with the discussion of a disease that is neither new nor rare. Syphilis is one of the oldest as well as one of the most prevalent diseases to which man has fallen heir. No disease is more important, nor more variable in its manifestations. Any method that assists in the diagnosis of so treacherous a disease is to be taken very seriously, as no disease is more difficult to diagnose in many cases than is syphilis.

Prior to 1905 when Schaudinn and Hoffman discovered the spirocheta pallida which they afterward named treponema pallidum, a great deal of experimental work has been done in syphilis, but none of it proved immediately available in the diagnosis and treatment of the condition. Among the investigators working along this line may be mentioned Ricord, Fournier, Metchnikoff and Roux.

Fournier first established the luetic origin of tabes and paresis some forty years ago, but spoke of them as parasyphilitic or metasyphilitic, whereas we now know that they are actually syphilitic.

Metchnikoff and Roux first succeeded in inoculating the disease into monkeys and apes in 1903.

In 1905 Schaudinn and Hoffman discovered the corkscrew shaped organism which they considered to be the cause of the disease, and which has since been cultivated by Noguchi and Moore and absolutely proven to be the cause.

In 1907, Wassermann and Bruck working in Wassermann's laboratory applied the complement fixation phenomenon of Bordet-Gengou to the diagnosis of syphilis, and this reaction, termed the Wassermann test, is today recognized all over the world as the most valuable method in the diagnosis of syphilis, although it has many times been attacked.

This test is one fraught with many difficulties and chances for error if the greatest care is not taken, but in the hands of competent laboratory workers is capable of aiding very greatly in the diagnosis of the disease.

Four or five years after the origin of the Wassermann test Noguchi showed that a certain number of syphilitics, especially treated and latent cases, would respond to the intradermal injection of an extract of the treponema pallidum by the production of a specific skin reaction. However, Noguchi did not claim that this would replace the Wassermann test, but that it would be found to be positive in many cases that gave a negative Wassermann reaction. In fact he looked upon it as a sort of complement to the Wassermann, as the Wassermann was most likely to be positive in the active secondary cases, while the luetin, as it is called, was least likely to be positive in these cases. Many other tests have been proposed for the diagnosis of this protein malady, among which may be mentioned the miostagmin reaction, the epiphanin reaction, Landaus-

iodin test, but none of these have met with very much favor and after brief trial have been dropped by nearly all except their originators.

The Wassermann test has been used not only as a diagnostic measure but also as a control in the treatment of the disease.

Many modifications of the original reaction have been brought out in the attempt to simplify the test and make it more valuable to the practitioner. Among the modifications, those of Noguchi, Tschernogubou and Hecht-Weinberg have met with the most favor.

However, it is this very attempt to simplify the test, and the consequent multiplicity of modifications, that has had a tendency to bring the test somewhat into disrepute with those physicians who are not acquainted with the variable results sometimes obtained by different workers, and by the same workers at different times. There may also be some disturbing factors in the blood which interfere with the proper performance of the test.

However, if these factors are taken into consideration, the Wassermann test stands today as it has stood for the last ten years as the most accurate laboratory method at our command, and the most important and constant symptom of syphilis that exists. I speak of it as a symptom of syphilis, for that is all it is. It should never be taken by itself as an absolute indication for or against the existence of lues, although a positive result obtained by a competent man is almost certain indication of its existence if we can rule out the existence of several other diseases any one of which is usually easily distinguished from it. Among these diseases may be mentioned frambesia or yaws, leprosy, carcinoma, malaria, scarlatina and the post-anesthetic state.

The Wassermann test has a greater positive than negative value. It is positive in the blood serum of about 80 to 90 per cent of primary cases after the seventh week, while in the first week it is usually negative. However, its presence in this stage is not of so much diagnostic importance, as a search for the spirocheta with the dark field, or some of the numerous staining methods, or the India ink method is frequently successful.

In untreated secondary syphilis the reaction is nearly always positive. Boas, in a test of a large number of untreated secondary cases, did not find a single negative, while Kolmer had a like experience. The figures of different workers for this stage show from 90 to 100 per cent positive.

However, it is in the tertiary cases that the test is of the most value, as the character of the eruption, etc., following the primary sore, makes the diagnosis in the secondary stage a comparatively easy matter many times, but the multiplicity of manifestations of tertiary syphilis makes it frequently very difficult to diagnose. Untreated tertiary cases give about 95 per cent positive, while treated cases run about 75 per cent.

Wile has shown that about 30 per cent of secondary cases have a positive reaction in the spinal fluid, showing that the disease has already attacked the central nervous system.

The Wassermann test has been of very great value in the diagnosis of the so-called parasyphilitic diseases.

In paresis the serum reacts positively in nearly 100 per cent of the cases, while the spinal fluid gives a positive in over 90 per cent. However, in certain cases of paresis the reaction in the blood serum is negative and in the spinal fluid positive and vice versa.

In active untreated cases of tabes the reaction in the blood serum is positive in from 95 to 100 per cent of cases, while in treated cases the reaction is positive in 40 to 50 per cent of cases. The reaction is positive in the spinal fluid in about 60 per cent of tabetics.

In cerebro-spinal syphilis the reaction is positive in a lower percentage of cases than in paresis. In some cases a positive may be obtained in the spinal fluid with a negative in the blood-serum.

In tertiary syphilis even without cere-

bral lesions or manifestations the reaction is positive in the spinal fluid in a considerable number of cases.

In latent syphilis the reaction is positive in about 50 per cent.

In congenital syphilis showing manifest symptoms, the reaction is positive in 95 to 100 per cent, while in those cases showing no symptoms the percentage is much lower.

Colles' law which teaches that the apparently healthy mother of a syphilitic child can not be infected by that child, thus assuming that the mother has acquired immunity from the child, has been disproven by this test, as it has been shown that most of these mothers are really syphilitic themselves.

Likewise Pofeta's law, the converse of Colles', has also been disproven. Instead of immunity being conferred on the mother by the child, and on the child by the mother, these are really latent infections with the disease itself.

Many things of interest and value have been brought out by the routine use of the Wassermann in hospitals.

Walker and Haller in a recent article in which they give the results of 4,000 Wassermann's done routinely in hospital and out-patient work, show 600 positive, or 15 per cent.

McNeil in a routine examination of all colored patients entering the hospital shows positive Wassermann in 35 per cent and positive luetin in 18 per cent, making a positive test for syphilis in 42 per cent in all, many of the positives being positive with both tests. However, in this work no attention was paid to the previous administration of potassium iodide which has recently been shown by Sherrick to produce a positive luetin test in 99 per cent of those having large doses.

Falls and Moore find 18 positive in a routine examination of pregnant women, only one of the eighteen positive cases giving a history of syphilis.

These observers say that syphilis is usually latent in pregnant women. It is of extreme importance, however, to make a diagnosis in the pregnant women, as treatment during pregnancy may save both the mother and the fetus.

However, there is no field of medicine that offers greater opportunity to the Wassermann than the field of nervous and mental diseases. Holbrook, in a routine examination of 1,600 patients at the East Louisiana Hospital for the Insane, shows 11 per cent of those received in the past ten years to have a positive reaction, while only 2½ per cent of those received previous to that time show positives, thus showing that the death rate among the syphilitic insane is much greater than among the non-syphilitic insane.

Collins in a discussion of brain syphilis says that it is rarely prudent to make a diagnosis of neurasthenia till a Wassermann has been done.

Fornichese states that 35 to 40 per cent of miscarriages occur in women giving positive Wassermanns, while only .78 of 1 per cent of abortions occur in women giving positives, this apparently paradoxical phenomenon being due to the fact that it takes some time for the fetus to develop syphilis sufficiently to succumb.

This same author states that the large majority of mothers of still-born babes give positive Wassermanns.

Smities in a report of twenty-six cases of the comparatively rarely recognized condition, syphilis of the stomach, states that the diagnosis was necessarily based on the positive Wassermann test.

Moore in a discussion of 418 routine Wassermann tests in dispensary work comes to the following conclusions: "A positive test is of inestimable value in the diagnosis of syphilis in the medical dispensary. The unreliability of histories and the protean nature of the disease make it extremely difficult of correct clinical diagnosis in all cases. Fifty-six positives were obtained in the routine examination of 418 patients. Only 50 per cent of those with a positive test gave a history of syphilis.

Whitney after a statistical study of syphilis as seen in the out-patient depart-

ment of the University of California Hospital, comes to the following conclusions:

"If these figures convey nothing else, they should emphasize the necessity and value of the routine Wassermann examination. For all hospital cases this ought to be done on all medical, nerve and obstetrical cases at least. Where such lavish use of the reaction is not possible the indications for it should at any rate be broad. Patients who admit a previous syphilis, or who show strong evidence of its presence and who will probably be given antisyphilitic treatment in any case, need the testimony of the Wassermann less than patients who do not otherwise suggest syphilis, than by having a disease that may be due to syphilis, but need not necessarily be so. Large numbers of cases could be cited in which the diagnosis has been cleared up by the routine Wassermann in the absence of any suspicion. This has often occurred after long periods of failure to improve on other treatment. We feel that any obscure case of any kind ought to have a Wassermann. This is especially the case in which the patient's complaints seem out of proportion to the physical findings in cases in which the diagnosis of neurasthenia is too often satisfactory to the physician.

"Of the class of cases in which the Wassermann seems especially called for, may be mentioned all diseases of the central nervous system, all circulatory diseases, including cardio-renal and renal, all bone and joint diseases, all diseases of the eye involving retina, choroid, sclera, iris or lens, all liver diseases, all chronic digestive diseases, all tumors, all cases involving lymphatic enlargement, and all constitutional or metabolism diseases."

In the treatment of syphilis the Wassermann has almost as great value as in the diagnosis, all cases being treated should have Wassermann tests as often as practicable in order to more intelligently direct the treatment. No case should ever be discharged without several negative tests at least, these being done at intervals of three to six months for several years after the cessation of treatment and then once a year for several more years and some authorities say for the rest of his lifetime.

In my own experience I have often found a positive in patients that would formerly have been discharged as cured.

It is quite generally agreed that treatment should be persisted in till a permanent negative Wassermann is obtained.

The variation in the method of conducting the Wassermann test has had a tendency to bring the test somewhat into disrepute with those who are unacquainted with the methods of conducting the test, as the different methods produce different results in a small proportion of the cases. These discrepancies in results have a tendency to shake the confidence of the profession in the test as a whole. But efforts are now being made to bring about a standardization of methods, so that one method will be used all over the world, or at least in giving the report, the method used will be stated.

Referring to the value of the luetin test it can be said that while it never had nearly so much value in the diagnosis of syphilis as has the Wassermann, the recent work of Sherrick, which has been confirmed by Kolmer and others, has decidedly shaken the confidence of the profession in this test. These men have shown that the administration of potassium iodide in 40 to 60 grain doses per day would give a positive luetin test in 99 per cent of cases. He also showed that the subcutaneous injection of peptone, agar, etc., would also produce a positive luetin test. However, if the previous administration of potassium iodide or any substance containing iodine can be ruled out, the test has considerable value especially in the cases giving negative Wassermann. It is the inactive cases that are the most likely to give a positive luetin reaction while the active cases nearly always give a positive Wassermann, as well as many of the apparently inactive cases. The luetin test shows a sensitization to the protein of the spirocheta while the Wassermann depends

supposedly on the production of a lipotropic substance as part of the life process of the spirocheta.

Thus the two tests overlap somewhat, but the principal value of the luetin test can be said to be found in the cases that give a negative Wassermann.

In addition to the Wassermann and luetin tests, several other methods are used in the diagnosis of syphilitic nervous diseases. Among these are the spinal fluid cell count, the various globulin reactions, Langes colloidal gold test, etc. All of these are of very great importance.

These tests are also used in addition to the Wassermann to check up the treatment of syphilis of the nervous system.

SUMMARY.

1. Syphilis is one of the most common of diseases, being present in about a tenth of the population of hospitals.

2. This prevalence of syphilis has been established by the Wassermann.

3. In cases which are manifestly syphilis is it well to do a Wassermann as a check on the clinical diagnosis.

4. The Wassermann should be a routine in all doubtful cases.

5. The Wassermann should be used to check the progress of treatment and to show whether a cure has been obtained.

6. No person with a positive test should be allowed to marry.

7. The luetin test is of distinctly less value than the Wassermann, but has distinct uses in cases giving a negative Wassermann.

8. The search for the spirocheta pallida is the method of choice in the first few weeks of the chancre, while later this does not have as much value as the Wassermann or both combined.

———R———

When and How to Remove Tonsils.

THOS. L. HIGGINBOTHAM, M.D., Hutchinson, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

As the tonsil menace becomes more thoroughly recognized, the perplexing question as to when they should be removed grows in magnitude. It has become the major question in preventive medicine and protective surgery, and occupies a more prominent position in our social welfare than does the problem of sexual diseases or the cancer peril.

From the fact that the problem is of such magnitude it would seem that the time is at hand for the medical profession to come to a common and united understanding as to what actually constitutes the real indication for the removal of tonsils. It is evident that we must agree on a definite but reasonable sign, the presence of which marks clearly the time for surgical interference. It must be a sign that the layman can understand and appreciate; it must be a simple but positive guide in our work. This point must be so definitely settled that no defendable argument can be introduced to the contrary; it must have the same universal acceptance as has the sound surgical law of emptying the uterus of a dead foetus or the removal of a diseased appendix.

If we consider the problem in an unbiased way we will come to the mutual understanding that Disease is the sign for the removal of tonsils, therefore I conclude that disease marks clearly the exact time for performing the operation.

It is not claimed that diseased tonsils have a beneficial function, but that they are detrimental is generally conceded.

This commonly accepted point of view places a heavy burden on the attending physician. His failure to prevent the disease extending to other parts of the body is unpardonable. He is morally obligated to act at that definite time when he is able to render the greatest remedial benefit; he must accomplish the maximum of good with the minimum of risk.

This two-fold good is accomplished only in the early hours of the disease; not days, weeks or months after, but at the very beginning of the malady.

The medical profession is not justified in continuing to be a passive agent in disseminating diseases of the tonsils. The practice of temporizing must be abolished

for a more effective procedure. Medical advancement makes its adoption as necessary as was aseptic surgery or the measures for the prevention of tetanus.

Had we come to this point of view a quarter of a century ago, our present army would no doubt be 25 per cent more proficient, and rejections from physical defects would be reduced by half.

Epidemics in the cantonments are due almost entirely to diseased tonsils; they are laboratories incubating the meningococcus, pneumococcus and Klebs-Loeffler bacillus. Would to God we were given the power to remedy this evil.

From clinical knowledge we know that all patients who have their tonsils removed when they are twenty-five years old, were in need of the operation when they were twenty years younger; they needed relief twenty times as bad at the early age. The harm that comes from these adult patients is beyond calculation. They have been perambulating incubators and disease carriers as a consequence of a false custom of practice. It is now the duty of the medical fraternity to correct this evil.

No adult has a moral, social or legal right to expose helpless little children to communicable diseases. Even physicians should make sure that they themselves are never the direct or indirect medium through which diseases of the tonsils are conveyed.

It has not been definitely established that undiseased tonsils have a beneficial function. This, however, does not give us tangible reason for advocating the routine removal of the newly-born infant's tonsils purely as a matter of prophylaxis. This stand would be extremely radical, but no more so than our present practice of permitting patients to carry diseased tonsils from childhood to the grave, or procrastinate the operation till the ears, heart, joints or kidneys are permanently damaged.

We must not be positive or negative extremists, but take the sensible stand of beginning our fight when disease begins its fight; our combat starts when disease is first discovered.

This will give diseased tonsils the same rational treatment that diseased appendices receive; it brings to the bedside and home a dependable measure; one that is both prophylactic and curative; one that sterilizes, one that protects.

It is unnecessary to enumerate the many afflictions that follow in the wake of diseased tonsils; we know the entire body is in constant danger as a result of their existence and their cost exceeds that of any other one malady. They are the pests of our present civilization; to temporize with them makes the physician a particeps criminis in the disasters that follow.

Let us be more than "legalized tonsil tinkers"; let us cease to deceive the credulous public with sprays, swabs, gargles and internal medications which have no therapeutic value or protective benefit. It is fair to presume that a mastoiditis or an endocarditis, following mal-treatment of diseased tonsils, is no less reprehensible than is the general peritonitis that follows neglected appendicitis; neither is the medical treatment of diseased tonsils more scientific than the medical treatment of intestinal obstruction.

We must no longer be guided by precedent in our dealings with diseased tonsils nor cling to ancestral customs and continue to ignore established surgical laws to the detriment of our patients. We must be more practical and remove the tonsils when they first become diseased.

The tonsils become diseased in childhood; they lay the foundation for evil when physical resistance is weak; they maim and kill the very ones that have no voice in their own protection, therefore it becomes our humane duty to make tonsil surgery a childhood measure; it must be made as practical as extracting teeth, incising an abscess or administering castor oil.

In removing tonsils when they should be removed, the child is securely wrapped in a sheet and placed in the lap of the as-

sistant; a self-retaining mouth gag is inserted and the faucial tonsils removed with a simple snare. The pharyngeal tonsil is removed with a small LaForce adenotome.

This simple plan of dealing with diseased tonsils makes it a home measure, void of the danger from general anesthesia and loss of blood.

It is a radical departure from the well worn paths of habit and can be objected to only by the private hospital owner and anesthetist; however, it is a "safety first" measure, intended for the "safety first" physician and parent.

Spiritual vs. Medical Advice—Report of a Case.

D. D. WILSON, M.D., Nortonville, Kansas.

Read before Jefferson County Medical Society, November, 1918.

Gentlemen: Your secretary has requested me to write a paper, report a case, or do any other thing I might see fit for the edification or amusement of this Society. So in turning the matter over in my mind I concluded to report a case by reading a letter I received from a patient many years gone by. Thinking the direful results following my handling of this case might serve as a warning and check to all of us in the future and cause us to be very careful in giving our advice.

This patient, a married lady twenty-six years of age, two children, seems to have had a fairly normal life up until the age of twenty-four, she then began complaining of some pelvic trouble and at the time I was consulted had been in the hands of many physicians and surgeons. I found her in bed, looking very comfortable indeed, but she gave me a history of so many things I could not digest them and asked her to write her feelings on paper so that I might take plenty of time to interpret her symptoms. She told me she had been on the operating table many times and that numerous organs had been removed. Her uterus and her uvula, her ovaries and her omentum, her coccyx and her corns, her appendix and her appetite and many other things she could not recall. In a few days I received the following letter, which I will now read:

"Dr. Wilson: How do I feel when I overdo? Stand on my feet. The half cannot be told. I raise up from left side to sitting position then on my feet in a moment. I am holding my breath seemingly while I stand and often lying down. The thumping through my body is immense and the most prominent feature for a few moments and it seems to me I can't breathe. I grunt, there is no sound except that from the pallet. Seems to me my breath is going less and less till I begin moaning and crying, then the spine through small of back clear through and across, also shoulder blades clear through me, back of neck and head, top of head, I am in confused condition, ringing in ears, blindness, then light flashes, etc. I want to throw my head back, draw my knees up cramping through bowels (as there is always pain in them), burning in urethra. Rubbing my spine relieves me much. Then pain is more severe through front, shooting pains through me in paroxysms, ears, head, tongue and left side of face, *always left side*, never such pain in right side of jaw and ear and tongue. I cry, then laugh and talk, my tongue is quite thick, afterwards feels sore. Always ends up in severe pain in head over one eye and top and back of head or in the bowels. Extremities hardly ever in both at same time although I have had it so.

"After I get quiet enough to go to sleep (which means after every one else is fast asleep or very quiet) I will wake up in a tremble, smothering and fighting for breath until I am perfectly exhausted. Chilling, then warm, and my nights and often weeks are made up with the above and the following in turn: Hiccoughs, belching, gagging, sometimes vomiting, can't eat much of anything for days, tight bands about my wrists, neck, stomach and ankles. I feel like I was too near pounded up to move, yet I move, but one trouble is seated in small of back and under shoulders in this style they connect and the

throbbing through stomach draws and chokes me. I *know* the trouble is much in these regions and head.

"This is my first and I assure you I will never trouble you with so much again, for I rather object to telling my nervous troubles, but I thought you ought to know and will say I can stand all this and I don't know how much more for as many years as I can. If I know I am not injuring my condition. If I can feel sure you understand me perfectly, I will do as you say, let come what will, if I know it will prove best.

"Your opinion please.

"P. S. Sick headache will follow this writing."

After careful consideration I advised her husband that she required a spiritual adviser, not medical. I had little thought at that time how far-reaching this advice might be, and am prompted to warn my fellow physicians about giving advice in cases of this nature promiscously. In this case it was taken literally and the result was that the minister carried his treatment too far, resulting in great scandal in the church of which he was pastor and no lasting benefit to the patient.

The question in my mind is: Am I guilty of wrong-doing in giving this advice? If so, to what extent?

I have thought the minister was overzealous in his treatment and if I am in any way responsible, he should have conculted someone before taking such radical action upon himself.

Moral: Be cautious and careful about advice.

R

Excerpts—By The Prodigal.

From the enormous amount of pathological literature presented in our medical journals, a has-been gets the idea that "the laws of both mind and body can be generalized from pathological data." But, as suggested by Buckle, the best way of arriving at a theory of disease is by beginning with the theory of health; and the foundation of all sound pathology must be first sought in an observation, not of the abnormal, but of the normal functions of life. Physiology is the basis of pathology, and the laws of disease are to be raised, not from the phenomena presented in disease, but from those presented in health. In other words, pathology should be investigated deductively rather than inductively, and morbid anatomy and clinical observations may verify the conclusions of science, but can never supply the means of creating the science itself.

A lack of accurate knowledge of the normal state of the nervous system on the part of neurologists is the main cause of difference of opinion in expert testimony in cases of the criminal insane. With all the pathological investigations but little has been accomplished as yet, if expert testimony is to be taken as the governing principle in deciding the fact of sanity or insanity, temporary or permanent.

OCCUPATIONAL THERAPY.

To be occupied in useful work is a prophylactic for old age. Our bodies will last five times as long as it takes them to mature. It requires about ten years longer for man's mental faculties to approximate maturity than for his physical organism. Man's body matures, remains stationary for a time, declines, and is returned to earth. The best in man grows all the time.

While the virile in man is the engine of the doer—the man in action, the best in man is produced when the virile is under domination.

A physician not long ago got an embarrassing notoriety by jokingly saying to his class that we all should be chloroformed at forty years of age. There is a limit to the physical life of an organism and hence to intellectual and mental activity through that medium. The physical or virile in man dominates to about the fiftieth year, from that on the mental. Man should be at his best mentally between the ages of fifty and seventy. He may be old at thirty and young at eighty.

We are told that Cato did not begin the study of Greek until he was eighty years of age, and Plutarch began the study of

Latin at the same age. Hobbs, the English philosopher, published his best book when he was eighty-seven. Chevereul, forever immortal in scientific research, was busy as a bee at his work in his one hundred and third year. "Some of the foremost hustlers everywhere at present are past seventy. Active heads of great nations, great generals in the present war, big business men of the biggest business, leaders and go-getters of all descriptions in every direction you look have passed the seventy mark and are going some." "But little has been done as yet to establish man's age efficiency." Carnegie, in the hey-day of his industrial career, did much to establish a workaday age, when all his workmen who were listed at forty or older were liable to be junked at any time. As a nation we followed suit and it was becoming difficult for a man to get work if he was forty or over. It was the young men, just out of their teens, who were supposed to do the world's work best. Doctors were no exception to the rule. This war is showing us that we were mistaken. The forty-year-old and over man is coming into his own and proving worth while. Now is the time for the old doctor to renew his medical youth, if he has lapsed or grown weary in well doing. The old doctor can stay if he will. He can come back if he will. The young doctor can catch up if he will. And each and every one of them can give Old Father Time a run for his whiskers if they will only work —keep busy—and don't let grass grow under their pedal extremities. For Nature needs us all in her business and will keep us on earth just as long as we are useful and will work.

A SUGGESTION.

Would it not be germaine—or rather German—for the "Birth Control League" to insert the following Bolsheviki decree into their creed or platform: "Russian maidens under the jurisdiction of certain provincial Bolsheviki Soviets become the property of the State when they reach the age of eighteen years, and are compelled to register at the 'Government Bureau of Free Love.' Under the decree, a woman having registered has the right to choose from among men between nineteen and fifty a cohabitant husband. The consent of the man chosen is not necessary. The men have the same right to choose"—and it is only a matter of who gets there first. "This provision is in the interest of the State." "Opportunities for choosing such husbands and wives are to be presented once a month. Children born of such marriages are to become the property of the State."

In this way the State can raise its own soldiers. It would give an impetus to the incubator business. After the child is born it could be taken from its mother, the same as a calf from the cow, and put in an incubator and never know a mother or father, and there would be no home ties to be broken up when they were old enough for cannon fodder. "There would be no sorrowing or parting there." Pretty slick scheme. The citizen, if such he could be called, would be made for the State, as in Germany now, and not the State for the citizen, as in the U. S. A. This gives us an inkling of the higher civilization in Russia. The mistake of many such reformers is that they begin at the wrong end.

NEARLY SPOILED HIM.

A young man in our city who has a cleft palate happened into a Methodist experience or class meeting. After all the sisters and brothers had testified to all the good things the Lord had done for them, the preacher called upon the cleft-palate young man to testify as to what the Lord had done for him. The young man arose and said: "I non't know what the Lorn has none for you, but he nearly spoiled me."

ONE ON METHUSELAH.

In speaking of amazing incidents in church, Judge Huron of Topeka, a staunch Methodist, said that he attended a protracted meeting presided over by the Presiding Elder in his home town in Indiana. At the close of the revival the converts were assembled and among them was a

hardened old infidel and scoffer, who had been a thorn in the flesh of the religious community for many years, but who had been converted at last and was among the waiting converts who were ready to give in their religious experience before the large congregation. When it came the old man's turn to testify as to his conversion and change of heart he got up and the spirit evidently left him, for he got cold feet and he began in a stammering, hesitating voice, and said: "Brotherin and sis-sisterin—my father di-died when I was si-six ye-ye-years old and he has been dea-dea-dead a thou-thousand years."

MEDICAL FREEDOM.

At a meeting of the Medical Freedom League of North Dakota, held in Fargo, June 11, 1918, a resolution was adopted for the definite incorporation of the principle of medical freedom in the states and in the constitution of the United States.

They claim that Benjamin Rush, one of the signers of the Declaration of Independence, declared that "Medical freedom is as importance as religious freedom and should be as carefully guarded by the American people." Just so. The word *religion* is derived from the word *religio*, revering the gods. This so-called Medical Freedom League seems to have about as definite clean-cut knowledge of what it is clamoring for as the ancients had of their gods. What they want is independence of all constituted authority or prescription; on the political and social theory that all government is evil.

Humanity is more indebted, under greater obligation to the medical profession for health, life and happiness than any other profession. What statesmen, the business world and the theological world failed to do in Panama the medical world did. It did the same in Cuba, the Philippines, in the South, and is doing it in the armies and the world over—making this old ball a healthy place to live on.

TO THE MEDICAL PROFESSION.

Here's hoping that the skin of a cranberry will make an umbrella big enough to cover all your enemies.

PROPHYLAXIS.

As a precautionary and preventive measure against influenza and all other contagious diseases, why not have all persons who have to dine in public places eat out of nose bags?

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A Suggestion for Spanish Influenza.

In view of success obtained by Woolley, at Camp Greene, and by McCord, Friedlander and Walker at Camp Sherman, in preventing diseases of the upper respiratory tract, such as meningitis, measles, pneumonia and diphtheria, by local use of Chlorazene and Dichloramine-T solutions, it is reasonable to believe that equally good results can be obtained with the same remedies in the prevention and cure of Spanish influenza.

The method employed at Camp Greene was to gargle or spray the throat three or four times daily with 0.25 per cent solutions of Chlorazene. The nasal pharyngeal tract was then sprayed twice a day, or more frequently, with 2 per cent Dichloramine-T solution in Chlorcosane.

This treatment, in association with aspirin and other salicylates, and the generous use of bacterins, has much promise.

Chlorazene, Dichloramine-T and Chlorcosane are obtainable from The Abbott Laboratories, Chicago, Illinois, which are supplying thousands of pounds of these products to the United States army and navy.

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Meningitis.

G. B. Kramer and W. B. Wright, St. Paul (Journal A. M. A., Aug. 31, 1918), report a case of streptococcic meningitis in a pregnant woman in probably the eighth month. The patient died before the diagnosis could be made, but cerebrospinal meningitis was revealed by the necropsy. The fetus was well formed and well nourished and showed nothing pathologic but a meningitis showing the same organisms as those in the mother's case. The comment is made that Rosenow and others have proved that in a large percentage of cases streptococci isolated from lesions of certain parts of the human body will, when injected into an animal, localize in similar parts and produce like lesions in the animal. This case of meningitis in the mother and child in utero seems to the author to demonstrate a genuine case of elective localization of streptococci in the human body.

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

ASSOCIATE EDITORS — C. W. REYNOLDS, C. C. GODDARD, P. S. MITCHELL, O. P. DAVIS, J. J. BROWNLEE, E. S. EDGERTON, W. F. SAWHILL, H. N. MOSES, C. S. KENNEY, D. R. STONER, J. A. DILLON, E. M. CARTER.

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Notice.

Notices were sent out a few days ago to officers of county societies stating that on account of the fact that Dr. Barney, acting secretary, had accepted a commission and had been called into service, the Editor of the Journal had been appointed by the President to act as Secretary. As we go to press the information comes that Dr. Barney has not been called into service and will continue to fill the position as acting secretary. Officers of county societies will therefore please ignore the notices sent them from this office.

Help Wanted.

There are too many county societies in the state that have no regular meetings. There are too many counties in the state that have no organizations. There are too many eligible men in the state that do not belong to the society.

We are starting a campaign to remedy at least one of these faults and we shall need a lot of help.

In the first place we should have six hundred new members. There are at least a thousand eligible men in the state that are not yet members of the Society. Some of these are just waiting to be asked, others may need a little coaxing.

Application blanks and literature will be sent from this office to every eligible nonmember in the state, as fast as we can get the names and addresses. Those living in counties where there is no organization will be asked to send their applications direct to the secretary, and will be referred to the Councillor of that district, as provided by the amended by-laws. Those living in counties where there is a county society will be given the name of the secretary of that society and requested to send their applications to him. In order that applications may be acted upon it is quite necessary that county societies should have regular meetings.

Every member of the Society can do something to help. There is a man in your town, or your neighboring town, who is eligible for membership, and if you will tell him about our Defense Fund and how it is used to protect him against suits for damage, and if you will show him a copy of the Journal, and tell him that for the small amount of dues he is asked to pay he will have both of these, you will be doing him a kindness and also be helping the Society. You will find an application blank in the Journal of this issue. Get him to fill it out and give you his check for five dollars (the membership fee and dues to January, 1920), then hand it to the secretary of your county society, or if there is no society in your county, send it to Dr. L. F. Barney, Kansas City, Kan.

Every county society is supposed to hold an annual meeting in December and elect officers for the following year. The secretary should report the officers so elected to this office. Annual dues are due and payable in January and a member whose dues are not paid by April 1 will stand suspended, according to our by-laws. Secretaries of county societies should send to this office a list of all members in good standing, with a check for the amount of three dollars for each member.

Losses in the Faculty of the Medical School of the State University.

During the past year the Medical School of the State University has lost to other institutions two men who had taken important parts in the development which has made the University of Kansas School of Medicine the ninth in size, as judged from attendance, in the twenty-eight State Universities conducting medical schools: Dr. John Sundwall going to the School of Medicine of the University of Minnesota and Dr. Ralph H. Major to the Henry Ford Hospital at Detroit. Each was given practically double the amount paid him by this state. Both believed that Kansas had a magnificent opportunity of building a large medical school of the first rank; and both left, feeling that the attitude of the state as expressed by its government had been too uncertain—progress not only of salaries, but of buildings, grounds, and equipment being neither given nor assured. The lack of these became especially striking when the National Government called upon the medical schools to play such an important role, as was shown in the shortage of doctors and the general need for medical facilities.

Dr. Sundwall, who held the degree of Ph.D. from the University of Chicago and M.D. from Johns Hopkins, had been the head of the Department of Anatomy for the past six years. He was also the secretary of the medical faculty and later he was chairman of the committee on student health. He developed the Department of Anatomy and took a great interest in the organization and development of the Medical School. As chairman of the health committee he organized an infirmary and health service which accomplished a vast amount of work with a very small amound of funds.

In the four years Dr. Major was in the University he organized a Department of Pathology which was recognized by the high standing accorded his students wherever they went—one of whom now occupies an important place in the Department of Pathology of Yale University. He also developed and catalogued the museum and the facilities for animal experimentation. In addition to this he did much research and wrote several articles as a direct result of it. Dr. Major had been a graduate student at the University of Chicago. He obtained his degree of Doctor of Medicine from Johns Hopkins University, spending a year as an interne there. He then spent two years in Germany under Muller; and one year at Leland Stanford University, coming to the University of Kansas from there.

It is impossible at the present time to fill the positions left vacant by these able men; and it is to be regretted that in these times of the constantly dwindling number of physicians and medical students that the parsimonious policy of our officials and legislators has necessitated the loss of such teachers to the state.

The Needs of the Medical School.

The medical school is sadly handicapped by lack of funds. It is not very creditable to the state that the best men on the faculties of the various departments of the university should repeatedly be lured away by larger salaries and better prospects. The medical school has many times suffered from the loss of its best qualified teachers.

Kansas does not regard itself as a cheap state, but it is certainly trying to conduct its medical school on a mighty cheap basis. The Medical Department of Minnesota University pays Dr. Sundwall $6,000. It has an attendance of 280 and an appropriation for salaries and maintenance of $311,410 and for hospitals and dispensaries $100,200. The total appropriation for the medical department being a little more than $1,470 per student. Kansas appropriates for the use of its medical school, with an attendance of 145, for salaries and maintenance $39,203 for hospitals and dispensaries $14,500. The total appropriation for the medical school in Kansas is $370.36 per student. There are at least fourteen state medical schools

which secure larger appropriations than the Kansas school.

We have always believed that one of the greatest needs of the medical school was the unanimous support of the medical profession of the state. The school has a great many very sincere friends in the profession, but there are a great many more who are too indifferent to be classed either as friends or unfriends. There are physicians in Kansas who really do not know that the state has a medical school, and there are a great many others who apparently do not know it. From the fact that it has an attendance of only 145, we must presume that there are a great many physicians in the state who are not familiar with the high standards of the course given. Otherwise one can hardly understand why so many students go elsewhere for medical instruction.

One of the arguments used against an adequate appropriation for the medical school was that the demand for such an institution, as indicated by the attendance, was too small to justify a large expenditure of the state's funds. Another argument used was that the medical profession was far from unanimity in its support of the school. We believe the latter argument was of quite considerable influence, for there has been very little interest shown by the profession in legislative matters concerning the school.

It is not possible now to increase the attendance of the school, but it is not too late to show the members of the next legislature that we are for the school and that we expect an appropriation for it that will enable it to maintain its present standard and show as much progress as like schools in other states.

If each of you will take a little pains to impress your representative and senator with the idea that the medical school is one of the most valuable and important of all our state institutions and should have a better appropriation, it will help a great deal.

In another issue we hope to give you an idea of the work that has been done by the Medical School during the past year.

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In the Journal of the A. M. A. for November 9 there are death notices of 168 physicians and in 122 of these the cause of death is given as pneumonia or influenza.

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A report by Solomon Strouse and Leon Bloch on 500 cases of influenza appears in the Journal A. M. A., November 9. Their findings differ in no essential way from the reports of other clinicians. One or two observations, however, may be of particular interest. They report three cases in which three doses of a vaccine had been administered and influenza subsequently developed, and over twenty cases in which one or two doses of vaccine had been given and later typical attacks of influenza and pneumonia developed. In regard to contagiousness they say: "All of the internes who became ill had been in close contact with the patients, and many of the nurses who attended influenza patients subsequently became patients themselves despite the fact that they took precautions to wear face masks while on duty taking care of patients, and to wash their hands in antiseptic solutions before leaving their patients."

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Deaths.

Dr. Karl Bieber, Tipton, Kansas. Born in Osborne County, Kansas, July 28, 1884. Graduated at Kansas Medical College, 1909. Died at Tipton, Kansas, October 14, 1918, of Spanish influenza. He was a member of the American Medical Association, the Kansas Medical Society, and the Mitchell County Society.

Dr. Carl Logan Brown, Cawker City, Kansas. Born at LaPorte, Indiana, April 23, 1885. Graduated at Kansas Medical College in 1913. Located at Cawker City, Kansas, until called to report at Ft. Riley, September 21, 1918. Was taken sick October 5, and went to Bennington, Kansas, where his wife is with her parents. He died there October 9, 1918, of Spanish in-

fluenza. He was a member of the American Medical Association, the Kansas Medical Society, and the Mitchell County Medical Society.

Lieut. Carl Calvin Culver, M. C., U. S. Army: Burlington, Kansas; University of Kansas, Lawrence and Rosedale, 1911; aged 31; a Fellow of the American Medical Association; on duty at Camp Grant, Rockford, Ill.; a specialist on diseases of the eye, ear, nose and throat; died at Camp Grant about October 6, from pneumonia, following influenza.

Clark Levitt Myerly, Burr Oak, Kansas; University Medical College, Kansas City, Mo., 1913; aged 32; a member of the Kansas Medical Society; died at his home, October 21, from influenza.

William H. H. Smith, Council Grove, Kansas; Northwestern Medical College, St. Joseph, Mo., 1902; aged 39; a Fellow of the American Medical Association; died at his home, September 28, from cerebral hemorrhage.

Robert M. C. Gavin, Tonganoxie, Kansas; Philadelphia University of Medicine and Surgery, 1878; aged 81; for many years a practitioner of Lebo, Kansas; died at his home October 5.

Lieut. Glenn Elbert Haughey, Wakeeny, Kansas; aged 34; a graduate of the Kansas Medical College, Medical Department of Washburn College, 1908; died at Fort Oglethorpe, of influenza, about October 20.

Alfred F. Skillman, McCracken, Kan.; Northwestern Medical College, St. Joseph, Mo., 1885; aged 61; died at his home recently, from pneumonia.

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Commissions Offered and Ordered to Duty on Acceptance.

To Fort Oglethorpe—Capts. O. C. Baird, S. Steele, Chanute; C. D. Blake, Ellis; H. G. Shelley, Mulvane; W. F. Osburn, Parsons; W. H. Carter, Lieut. A. E. Gardner, Wichita.

To Fort Riley—Lieuts. C. J. Mills, Lebo; G. D. Ruth, Moundridge; J. B. Blades, Randall.

To Camp MacArthur, Texas—Capt. F. F. Netherton, Wellington.

To Fort Des Moines, Iowa—Capts. J. T Faulkner, Lansing; C. E. Ross, Wichita.

To Fort Oglethorpe—Capt. C. S. Trimble, Emporia; Lieut. C. B. Bailey, Hawkinsville.

To Fort Riley—Capts. H. Morrison, Smith Center; E. M. Seydell, Wichita; Lieuts. C. L. Brown, Cawker; J. F. McNaught, Girard; W. E. Knox, Norcatur.

To Camp Grant, Ill.—Lieut. L. M. Beatson, Ashton.

To Camp MacArthur, Texas—Lieut. P. D. Brown, Alton.

To Fort Riley—Lieuts. R. Laing, Concordia; R. B. Earp, Eldorado; H. R. Wilson, Harris; B. T. Prather, Peabody; H. A. West, Yates Center; R. A. Light, Chanute; W. L. Speer, Clay Center.

To New Haven, Conn., Yale Army Laboratory School—Lieut. F. L. Flack, Coffeyville.

To Camp Logan, Texas—Lieut. C. N. Petty, Altamont.

To Fort Riley—Capt. W. H. Walker, Kansas City; Capt. D. G. Buley, Sedgwick; Lieuts. L. E. Henderson, Coyville; S. Bailey, Garden City; I. E. Hardner, Kansas City.

To New Haven, Conn., Yale Army Laboratory School—R. W. Vandeventer, Wellington.

To Camp Beauregard, La.—Capt. G. F. Zerzan, Holyrood.

To Camp Bowie, Texas—Capt. R. R. Nevitt, Mildred.

To Camp Cody, N. M.—Capt. J. W. Simmons, Salina.

To Camp Pike, Ark.—Lieut. G. A. King, Maple Hill.

To Fort Oglethorpe—Lieuts. A. J. Wedel, Hesston; C. Mayfield, Hutchinson; C. F. Funk, Smith Center.

To Fort Riley—Lieut. W. P. Calahan, Wichita; Capts. C. A. Fisher, Fontana; C. F. McNair, Haven; E. L. Asbell, Kansas City; J. S. Fulton, Kiowa; E. Lieurance, Neosho Falls; Lieuts. H. Richert, Goessel; P. F. Wesley, Haviland; P. C. Anders, Hays; W. E. Michener, Ottawa; O. C. Lowe, Paola; L. S. Fisher, Raymond; G. H. Grieve, Turon.

To New Haven, Conn., Yale Army Laboratory School—Capt. H. N. Moses, Salina.

To Camp Dodge, Iowa—Capt. C. A. Parker, Maize.

To Camp MacArthur—Capt. W. C. Chaney, Independence.

To Camp Pike, Ark.—Lieut. C. D. Mills, Freeport

To Fort Oglethorpe—Capt. J. T. Reid, Iola; Lieuts. P. A. Loyd, Culver; D. L. Morgan, Emporia; A. R. Hatcher, Wellington.

To Fort Riley—Capt. T. E. Smith, Independence; Capt. R. W. James, Winfield; Lieuts. H. L. Galloway, Anthony; E. D. Tanquary, Bronson; R. Algie, Linn; O. W. N. Austin, Mayetta; H. M. Bentley, Sterling; G. R. Little, Wichita.

To Camp Grant, Ill.—Lieut. R. M. Troup, Garden City.

To Fort Oglethorpe—Capts. J. G. Kennedy, Altoona; J. L. Grove, Newton; Lieut. E. L. Kalbfleisch, Newton.

To Fort Riley—Capts. B. R. Riley, Benedict; H. A. Browne, Galena; F. K. Meade, Hays; Lieuts. L. M. Hinshaw, Bennington; C. R. McFarland, Blue Rapids; A. Johnson, Clyde; R. P. Pierce, Dunkirk; W. R. Morton, Green; C. N. Johnson, Wichita.

To Camp Sherman, Ohio—Capt. W. F. Bowen, Topeka.

To Fort Oglethorpe—Capt. L. F. Barney, Kansas City.

To Fort Riley—Lieut. E. R. Cheney, Gypsum; Capt. R. J. Harlin, Erie; Lieuts. R. B. McKinney, Augusta; W. R. Scott, Baxter Springs; W. Robertson, Caldwell; F. W. White, Emporia; T. J. Brown, Hoisington; H. B. Talbot, Hoyt; F. D. Lose, Madison; W. S. Hunter, Norton; R. E. Teall, Palco; D. W. Melton, Preston; W. E. Mowery, Salina; M. Mehrle, Walnut; W. R. Fisher, Wichita.

To Camp Dodge, Iowa, Base Hospital, for instruction—Capt. W. A. Klingberg, Elmo.

To Camp Logan, Texas—Capt. J. B. Carter, Wilson.

To Camp Pike, Ark., Base Hospital—Lieut. R. G. Smith, Marion.

To Fort Oglethorpe for instruction—Capts. J. S. McBride, Lyon; H. E. Nelson, Sharon Springs.

To Fort Riley for Instruction—Lieuts. C. F. Atwood, Abilene; W. W. Scott, Athol; G. E. Martin, Cullison; A. W. Corbett, Emporia; M. L. Brakebill, Florence; F. L. Depew, Howard; D. J. Moore, Idana; P. L. Jones, Lenexa; J. W. Demand, Lincolnville; H. W. Davis, Little River; F. R. Blake, Marquette; O. M. Cassel, Norton; W. O. Poston, Quenemo; T. A. O'Connor, C. S. Wolfe, Topeka; E. S. Haworth, Viola; E. A. Myers, Wakefield.

Orders to Officers of the Medical Corps.

To Camp Crane, Pa.—Capt. F. J. Walker, Wichita.

To Camp Custer, Mich.—Capt. C. E. Ross, Wichita.

To Camp Devens, Mass.—Capt. L. S. Wagar, Florence; Base Hospital, Lieut. H. A. Alexander, Topeka.

To Camp Dodge, Iowa—Capt. F. A. Eckdall, Emporia.

To Camp Greene, N. C.—Lieut. E. D. Rodda, Arma.

To Camp Sherman, Ohio—Lieut. M. F. Russell, Great Bend.

To Rock Island, Ill.—Capt. W. D. Hunt, Emporia.

Honorably Discharged—Lieut. J. L. Work, Topeka; Lieut. O. J. Dixon, Mound Valley.

To Camp Sheridan, Ala.—Capt. E. A. Drake, Natoma.

To Camp Travis, Texas—Capt. A. A. Shelley, Galena.

To Fort Benjamin Harrison—Lieut. F. P. Mann, Valley Falls.

To Fort Oglethorpe—Lieut. O. R. Brittain, Salina.

To Fort Riley—Lieut. W. L. Butler, Stafford.

To Fort Sheridan, Ill.—Lieut. E. M. Ireland, Coldwater.

To Camp Crane, Pa.—Capt. H. Wilkinson, Kansas City.

To Camp Zachary Taylor, Ky.—Capt. W. H. Carter, Wichita.

To Fort Oglethorpe—Capt. H. Atkins, Pratt; Lieut. W. S. Prout, Concordia.

To Fort Riley—Lieut. J. E. Graf, Salina.

To Camp Dodge, Iowa — Lieut. R. B. Earp, Eldorado

To Camp Sherman, Ohio—Lieut. A. E. Gardner, Wichita.

To Camp Crane, Pa.—Capt. A. D. Jones, Wichita; Lieuts. H. A. Alexander, F. L. Loveland, Topeka; Capt. H. G. Shelley, Mulvane; Lieut. C. W. Zugg, Great Bend.

To Camp Knox, Ky.—Lieut. W. G. Burton, Wichita.

To Camp McClellan, Ala.—Capt. E. A. Reeves, Kansas City; Lieut. R. Algie, Linn; Lieut. J. B. Blades, Randall.

To Camp Zachary Taylor, Ky.—Lieuts. M. Hall, McPherson; E. G. Padfield, Salina.

To Camp Crane, Pa.—Lieut. E. H. Schlegel, Wichita.

To Camp Grant, Ill.—Lieut. L. J. Pierce, Englewood.

To Camp Kearney, Calif.—Lieut. W. Doster, Coldwater.

To Camp Logan, Texas—Capt. C. L. Randall, Neodesha.

To Camp Newton D. Baker, Texas—Lieut. R. S. Pickler, Beloit.

To Denver, Colo.—Lieut. C. P. Ensign, Lawrence.

To Fort Oglethorpe—Lieut. A. J. O'Leary, Burr Oak; Capt. M. Hahn, Arkansas City.

To Fort Riley—Lieut. H. W. Gootee, Topeka.

To Jefferson Barracks, Mo.—Lieut. D. C. Dodds, Summerfield; Lieut. A. B. Occhsli, Stockton.

To Newport News, Va.—Capt. J. W. Cheney, Wichita.

Honorably discharged on account of physical disability existing prior to entrance into the service, Capt. W. A. Nixon, Great Bend.

With the American Red Cross at the Front.

Arm and leg wounds compose a large majority of the injuries received in battle, hence there is an enormous demand for splints.

The American Red Cross has taken over the job of supplying all splints to the American Expeditionary Forces, and in the vernacular of the streets, it is "some job." The demand for these particular articles is increasing at a great rate due to the increasing activity of American troops on the battle front.

To meet this demand the Red Cross has established a splint manufacturing plant of its own in a large French town not far from the battle front.

While the splint construction is not complicated, it must be exceedingly careful and delicate. The splints that fit on the upper portion of the leg or arm must be carefully padded with felt and sheepskin. This work is done by French women and by hand.

Most of the leg and arm splints are made of steel rods bent in the shape of a U and are about four feet in length. They taper from the bottom up to the top where a semi-circular steel rod, attached to each end of the U by a hinge, is padded well and attached. Upon the padded part rest the thigh or shoulder of the injured member. The wounded or broken leg or arm is bandaged between the two sides of the U. The bottom of the U is dented in order that a bandage may be attached to the bottom of the splint and the injured member for the purpose of pulling or applying the necessary weight to force the broken bones or torn muscles into place. It also serves to attach the splint to the foot of a bed or the front of an ambulance so that the wounded leg or arm may be elevted to any position which will give the greatest comfort to the sufferer.

There are numerous variations of this basic splint. Some have a hinge in the center of both sides of the U, so that an injured leg or arm may be bent at the knee or elbow and bound into position. Some have a hand rest at the end, by which the hand may be bandaged into an immovable position, so that injured muscles will not be moved by unconscious effort. Then there is the U splint with an unmovable padded steel circle at the top, which fits close to the leg or shoulder

crotch. A splint of this type is also made with hinges so that the arm or leg, stretched straight and fast, may be moved at the thigh or shoulder. There are small wire splints for the foot, the hand and the wrist.

All of them are made by hand in this factory, because of the lack of machinery. Even the welding and varnishing of the steel and wire, as well as the nickeling, is done in the Red Cross factory.

This is only one of the many activities from which the American Red Cross has relieved the army. During the past few months the Red Cross has been forced to let contracts to various private manufacturers to furnish a sufficient supply of these necessary hospital appliances, but with the growth of its organization it has established its own manufactory in the war zone of France, in order that there may be fewer transportation delays and better service in the work of relieving as much suffering as possible among American wounded.

———R———

Causes of Cancer.

In an address delivered to the employes of the War Department at Washington, Dr. Wm. J. Mayo is reported to have made the following statements in regard to the causes of cancer:

"Certain occupations may lead to the contraction of cancer. Workers in aniline dyes absorb deleterious substances, which get into the urine and sometimes causes cancer of the bladder. Cobalt workers often have cancer of the lungs from the inhalation of irritating particles of cobalt, and workers in tar develop irritations at points where the tar comes into contact with the skin which may develop into cancer. Soot has an irritating effect on the skin, and the frequency of cancer of the groin among chimney sweeps is proof of this. Those who work in arsenic and its preparations sometimes absorb enough to overstimulate the skin, and cancer, especially of the hands and feet, may develop. Persons working with the X-ray often develop dermatitis of the hands, leading to cancer.

"There are several kinds of cancer, some of which attack the skin, mucus membranes and excreting glands, while others attack the bones, muscles and connective tissues. It is believed that in all of them some lesion—*i. e.*, some point of irritation, is necessary before the cancer can form. It is probable that a majority of human beings are immune to cancer, that a lesser number possess a partial immunity, while a minority are without the protective agencies which render the lesions harmless. The condition of such persons is described as 'precancerous.'

"The lesions which may lead to cancer are classified as (1) congenital, (2) traumatic, (3) chronic irritative. The first class includes all sorts of moles, warts and benign tumors. The second includes injuries, such as bruises, wounds and burns.

"The third class includes all sorts of mechanical, chemical and infectious irritations, such as those caused by occupation, and is the greatest factor in the production of cancer. The potency of chronic irritation in producing cancer has been proved in many ways. For example, in India there are cattle which pull loads by means of ropes passed through holes bored through the base of the horn. Cancer at the base of the horn is very common among these cattle, and is seldom seen in others. A Copenhagen scientist found that rats in certain American sugar warehouses frequently had cancer of the stomach. He learned that these rats ate a kind of cockroach which was infected with a parasite that irritated the stomachs of the rats, and he was able to produce cancer in other rats by feeding them on these cockroaches.

"There is abundant evidence that external cancer in man is nearly always caused by some sort of an irritation, and scientists believe that internal cancer may often be due to the same cause.

"In parts of China where the head is shaved by the public barbers, the razors used are often dull and full of nicks, and the irritation of this scraping often causes cancer. Chinese men suffer from cancer of the pharynx and esophagus due to their habit of eating very hot rice, which is thrown into the mouth forcibly with chop sticks. Chinese women eat after their lords and masters, when the rice is cold, and they never have this kind of cancer. In India much cancer is caused by the chewing of betel nut. In some parts of the country women do not chew the nut, and are free of cancer of the mouth.

"Cancer of the mouth in civilized countries has been greatly reduced by good dentistry. Eighty-five per cent of the cancers of the lip occur in smokers. Formerly clay pipes, which became very hot, were much used, and there has been a notable reduction in the number of cancers of the lip since the clay pipe has gone out of fashion. Smoking, however, is the cause

of most cancer of the lip, the tongle, and the floor of the mouth.

"In Khurdistan, India, the natives wear baskets filled with hot coals across their abdomens to protect them from the cold, and more than fifty per cent of all the cancer in that region forms in the abdomen and groin, while in other countries such cancers are very rare.

"Gall stones, which cause a chronic irritation, are found in 85 per cent of all cases of cancer of the gall-bladder. Locomotive engineers and firemen frequently have cancer of the skin, due to exposure to the heat of the firebox. Cancer of the breast in women is believed to be largely due to the irritation of clothes, and especially of corsets. Among people who leave the breast uncovered, cancer of the breast is extremely rare.

"One-third of all the cancer in civilized men occurs in the stomach, although this is not true of animals or primitive people. It seems not improbable that the taking of very hot food and drink by civilized people may be the cause of this."

R

Yeast in Deficiency Diseases.

Interest in the use of yeast as a curative agent has been revived by the article of Hawk, Knowles, Rehfuss, and Clarke (Journal A. M. A., Vol. LXIX, No. 15, October 13, 1917, pp. 1243-1247). This article calls attention to the very valuable action of yeast (the authors used bakers' yeast) in various dermatoses, constipation, and miscellaneous conditions.

They did not include in the diseases in which they tried yeast certain conditions in which yeast has probably some value, and in one of which—beri-beri—it is well recognized as a curative agent. We refer to the so-called deficiency diseases. As much has been written recently concerning the etiology of these diseases, especially as correlated with the ingestion or rather the non-ingestion of certain foodstuffs, it may be well if we spend a little time to delimit what is well established in the etiology of these conditions from what is still conjectural.

The subject of the vitamins is well treated by Funk in his book "Die Vitamine, etc.", 1914, and in an exposition concerning the so-called vitamins, with especial reference to their chemical nature, etc., is to be found in American Medicine, Vol. XXII, No. 11 (complete series), Nov. 1916, pp. 751-756. It was Funk's theory that deficiency of a so-called vitamin in the food gives rise on the one hand to beri-beri and deficiency of another vitamin gives rise to scurvy. He calls attention to certain relations between scurvy and pellagra. Pellagra was regarded by him as being due to the absence of vitamins in the cornmeal used by the victims of this disease. The tropical disease "sprue" he also regards as due to vitamin deficiency.

Funk points out that yeast is very rich in vitamin, which he attempted to extract from yeast by chemical processes, but which he was unable to obtain in pure form. Funk did obtain from rice polishings a crystalline base which would promptly cure fowls that had already developed polyneuritis (a condition corresponding with beri-beri in man). He coined the term "vitamin" for this substance. Ever since the term "vitamin" has been used to designate substances of as yet undetermined chemical composition ingested by man, as a rule in his foodstuffs, small quantities of which are necessary for the perfect maintenance of his health.

McCollum recognizes only two so-called vitamins that thus far have been proved to be wanting in the so-called deficiency diseases of man—the fat-soluble A, the lack of which causes a variety of xerophthalmus, and the water-soluble B, the lack of which causes beri-beri.

The relationships of scurvy, pellagra, and beri-beri, have been pointed out by Williams (American Medicine, complete series, Vol. XXII, No. 11, Nov. 1916, pp. 756-762). For instance, there is a condition known as ship beri-beri, not due to the eating of rice, but appearing in crews who have made long voyages and who have subsisted especially on biscuit, or wheaten bread, and canned meats. This condition was regarded by Funk (see his book on the vitamins) as closely related to scurvy. At all events it seems to be regarded by Jour. A. M. A. as beri-beri (editorial article, Vol. LXX, No. 14, April 6, 1918; p. 1001), where such a condition is mentioned as having existed in the Norwegian mercantile marine. It may be that this is at least one of the conditions mentioned by Kellogg and Taylor (The Food Problem, 1917, p. 197), as "nutritional diseases which appeared in one of the armies of the present war, due to diets limited to white crackers and canned meats," and which "were promptly cured by the administration of water-soluble vitamin in the shape of yeast." Kellogg and Taylor also consider the possibility that pellagra is

due largely to the absence of water-soluble vitamin. This disease and its etiology have been carefully studied by both McCollum and by Goldberger, who contributed articles on the subject in the Sept. 21, 1918, number of the Jour. A. M. A. (Vol. LXXI, No. 12). These authors agree that the disease is primarily associated with the unsatisfactory character of three of the factors of the diet, a deficiency of "fat-soluble A," a faulty inorganic portion, and the relatively poor quality of the proteins. Goldberger would add to this combination the possibility of a low or inadequate supply of water-soluble vitamin.

Hess in his feeding experiments on infantile scurvy found that yeast exercised an important effect on the growth of children between one and one-half and two years of age, as evidenced by decided gain in weight. Fischer (Therap. Gazette, Feb. 18, 1917, pp. 91-94), used, with good results, autolyzed yeast together with improved diet in cases of children whom he regarded as suffering from vitamin insufficiency.

R

Psychological Handling of Tuberculosis.

Charles L. Minor, of Asheville, North Carolina, discusses the psychological handling of the tuberculous patient in the American Review of Tuberculosis for October. In no disease is the relation between mind and body so close and so important as in pulmonary tuberculosis. This fact must be recognized as an important factor both for prognosis and treatment, and the complete confidence of the patient obtained. A proper personal atmosphere is important for the welfare of the patient and is often better obtained in an institution than in the home, especially in a cottage sanatorium where a group of patients, socially and financially compatible, are all educated to a proper attitude toward each other and toward themselves. It is essential that the patient be seen for proper psychic treatment as well as supervision. At first twice a week, and after thorough acquaintance is established once a week, should be enough. When office visits become feasible a fifteen-minute interview twice a week and an hour for physical examination once a month is sufficient. The study of the mental side of the case will become so fascinating that the handling of the case becomes a pleasure rather than a task.

The tuberculous are by no means always or even often abnormal, as has been implied by some writers, though there is a good deal of neurasthenia and hysteria among them and they are apt to have a rather labile temperament. When one considers the terrifying effect for a person ignorant of the real nature of tuberculosis of first learning that he is suffering from this disease, it is no great wonder that it causes a fearful upset of his mental poise and easily produces in any but the most phlegmatic or the most self-controlled a temporary neurasthenia. There is no such school of character as tuberculosis bravely met and rightly faced. No doctor could want a more splendid work than to have a part in teaching these patients to master the bitter sorrow of sickness. He must be hopeful in order to inculcate hope. While there are many that cannot be saved, there are also many who can be restored to working efficiency for long periods or for good, and even in the long drawn out chronic cases life can be made useful and filled with interests and happiness if the patients are but taught to face it aright. A foolish optimism which refuses to see the truth is a miserable thing, that only doubles the sorrow of the patient when he comes to a realization of the facts. But a wise optimism can yet give him hope and a power to fight whose value cannot be overestimated in its effects on the success of our physical efforts. Finally the physician's endeavors should be directed not merely to curing the curable patients but to heartening the apparently hopeless ones to fight to the end.. (Minor, Charles L.: Psychological Handling of the Tuberculous Patient, Am. Rev. Tub., 1918, Vol. II, No. 8.)

R

Saving Italian Children from Malaria.

In the Pontine Marshes, famed in Roman history, where in other ages men fought and died—where hundreds and thousands, especially children, have died from Malaria, bred in the swampy wastes of the marshes—there the American Red Cross has begun a campaign to save Italian children from the ravages of disease.

The mothers of this fever-infested district work all day in the fields below the little hill towns where they live. Their children are weakened by insufficient feeding and fall ready victims to infection and contagion. Matters have been in very serious condition. The Red Cross, after an extended investigation, established twelve asili. or day nurseries, in districts which can be reached only on foot or mule back.

The result of the work there has been most satisfactory, not only in a material

way, for the children have shown marked improvement, but because of the psychological aspect of the situation. First, the mothers have been able to attend to their work, the while the children have been properly cared for. Then, the fathers at the front have been relieved of the anxiety, knowing that all possible was being done for their beloved ones.

In these asili the children are taught to apply themselves to little tasks with plenty of play between and are served with a plentiful meal in the middle of the day. The older children, who attend school in the villages and suffer from prevailing conditions, also come to the asili to get their mid-day meal, known as "Referione Scolastica," or school refreshment.

At this meal, in addition to all the nourishing food prepared from materials either brought from America or purchased in Italy, the children receive a large slice of white bread, an almost unheard-of thing in these little towns even before the war. The bread is made from American flour brought especially to Italy for the under-nourished and delicate children, and they also carry home another piece for their supper.

But no matter what the Red Cross or other organizations may do, their work, while beneficial, is only temporary. Malaria will not be driven from the Pontine Marsh district until sanitation is established and they are drained of the foul, gnat and malaria-breeding pools and bayous.

R

Influenza Symposium at A. P. H. A. Meeting.

The influenza epidemic will be made the most important subject of discussion at the December meeting of the American Public Health Association. Some of the questions which will be discussed are the following:

Is influenza vaccine efficacious as a prophylactic?

What type of vaccine is most useful?

Does it help as a therapeutic?

What about nose and throat sprays?

What are the results with convalescent serum?

What about the open-air treatment?

How can the health officer co-ordinate hospital, medical, health, and relief agencies in similar calamities?

How can we take advantage of the epidemic for the benefit of more adequate health appropriations and better community and personal hygiene?

The detailed influenza program is not yet ready as we go to press. The rest of the program will be substantially the same as previously announced. The papers read at the meeting will be published in the American Journal of Public Health.

Headquarters of the meetings will be at the Hotel Morrison, Chicago; the dates, December 9-12, 1918.

The secretary of the Association may be addressed at 126 Massachusetts Avenue, Boston, Mass.

R

Calcreose.

Calcreose is a creosote product, made in the United States of America by an American manufacturer. Clinicians have used it with good results in the treatment of all forms of bronchitis and especially the bronchitis accompanying pulmonary tuberculosis. It has been taken for long periods of time, and in large doses, without causing gastric irritation or discomfort; no burning, no nausea. Calcreose is also valuable in gastro-intestinal infections. Incidentally, the price of this product is far below that of other creosote products of foreign manufacture. The booklet, "Calcreose Therapeutics," which contains all information as to indications, dosage and method of administration, may be obtained by writing to The Maltbie Chemical Co., Newark, N. J.

R

Vaccines in Influenza.

After study of the evidence as to the value of vaccines against influenza, the Massachusetts committee recommended that the state encourage the distribution of the influenza vaccine intended for prophylactic use but in such manner as will secure scientific evidence of the possible value of the agent. It reported that the use of the vaccine should be considered experimental, and recommended that the state shall neither furnish nor endorse any vaccine used for the treatment of influenza. (Jour. A. M. A., Oct. 19, 1918, p. 1317.)

R

Sugar Treatment of Tuberculosis.

Domenico Lo Monaco, professor of physiologic chemistry of the University of Rome, has studied the influence of the secretions of sugar parenterally introduced. He found that when persons with copious bronchial secretions are given subcutaneous injections of 4 or 5 gm. of sugar (saccharose), expectoration rapidly diminishes and ceases completely in many cases. It is claimed that an intramuscular

injection of strong sugar solution is of considerable value in the treatment of the tuberculous in that by diminishing the bronchial secretion, it diminishes the cough and annoying night sweats. It is further suggested that the treatment will be useful in that it will decrease the amount of sputum scattered about by consumptives. (Jour. A. M. A., Sept. 28, 1918, p. 1083.)

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Ill Advised Public Health Articles.

A "syndicated" newspaper article which discusses Spanish influenza advises that "aspirin may be administered to relieve headaches and body pains." No doubt it would be to the interest of public health and the public pocketbook were medicines taken only on the advice of physicians. The objections to the lay use of aspirin was thus stated by the Council on Pharmacy and Chemistry:

"The public does not know, as physicians do, that headaches are merely symptoms of other sometimes very serious conditions, and that they are often the signal for the need of a thorough physical examination and diagnosis. It is true that they are often also the symptoms of very minor derangements, which will right themselves spontaneously; and that, in such cases, drugs like aspirin may give relief and may do no harm. The patient, however, is not educated to distinguish one class from the other, and therefore anything that tends to promote the indiscriminate use of such remedies as aspirin itself is not always harmless. Alarming idiosyncrasies are sufficiently common that the use of the first doses, at least, should require medical supervision. (Jour. A. M. A., October 19, 1918, p. 1337.)

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New and Nonofficial Remedies.

SOLARGENTUM-SQUIBB.—A compound of silver and gelatin containing from 19 to 23 per cent of silver in colloidal form. It is used in solutions containing from 1 to 25 per cent or more. It is also used in the form of bougies or suppositories. No precipitate is produced when sodium chlorid or albumin solutions are added to solutions of solargentum-Squibb. E. R. Squibb & Sons, New York. (Jour. A. M. A., Oct. 12, 1918, p. 1219.)

BENZYL ALCOHOL — PHENMETHYLOL. — An aromatic alcohol occurring as an ester in tolu and other balsams, and produced synthetically. It is being used as a local anesthetic by injection and by application to mucous membrane. It is said to be practically nonirritant and nontoxic in the ordinary concentration and dosage. From 1 to 4 per cent solutions in physiological sodium chloride solution are commonly used for injection anesthesia.

PHENMETHYLOL. — A non-proprietary brand of benzyl alcohol complying with the tests and standards for benzyl alcohol. Hynson, Westcott & Dunning, Baltimore, Md.

PNEUMOCOCCUS ANTIGEN (Rosenow), LILLY.—A pneumococcus vaccine prepared by digesting a suspension of pneumococci until the bacteria are partially autolyzed. E. C. Rosenow believes that the protective power of this vaccine is greater than that of one prepared in the usual way. It is marketed in 5 cc. vials, each cc. containing 20 million partially autolyzed pneumococci. Eli Lily & Co., Indianapolis. (Jour. A. M. A., Oct. 26, 1918, p. 1407.)

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Serums and Vaccines in Influenza.

Unfortunately, we as yet have no specific serum for the cure of influenza and no specific vaccine or vaccines for its prevention. The various treatments now being tried are experimental and their value will not be known until all the results are collected, which probably will not be until the epidemic is over. As to serum treatment, the only noteworthy new method so far is the injection in severe cases of influenzal pneumonia of the serum of patients who have recovered from such pneumonia. (Jour. A. M. A., October 26, 1918, p. 1408.)

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Dermatitis Venenata.

E. S. Lain, Oklahoma City (Journal A. M. A., Oct. 5, 1918), says that having practiced in the South he has had opportunities to observe various plants that can produce local poisoning of the skin, and during the past several years he has frequently noticed in hucksters and gardeners a form of dermatitis difficult to account for other than on the basis that it had been caused by some common garden vegetable. In the summer of 1916 Lain's attention was specially directed to the tomato plant as he had noticed several cases of the eruption following the gathering of tomatoes from rank and dewy-laden plants. He found no references to this cause in the available literature, but on referring to the reference department of the American Medical Association he learned of one French article that mentioned it. For several centuries, as is well known, the plant was regarded as poisonous, and not until the middle of the nineteenth century had

it become a common edible fruit. Most of the group to which it belongs contain poisonous alkaloids or glucosids which may be converted into a certain amount of hydrocyanic acid. According to Panmel, the tomato plant contains saponin among other active elements. This, according to physiologic chemists, when applied in soluble form to the mucous membranes, or delicate epithelium, becomes a violent irritant. The eruption that Lain has seen in recent years frequently begins as a mild stinging or itching on the dorsum of the hands, wrists and both surfaces of the forearms. In a few hours an erythema appears, followed by a papular eruption. All the patients gave a history of having exposed their hands and forearms to the plant. Two of the cases are reported. It is a little remarkable that this plant poisoning has not been more noticed by dermatologists and it may be rare or confined to certain soils or seasons. The author does not think it deserves a new nomenclature but can simply be numbered among the numerous causes of dermatitis venenata.

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Visceroptosis.

J. Riddle Goffe, New York (Journal A. M. A., Oct. 5, 1918), finds the only satisfactory original cause of visceroptosis in a bacterial infection. The structural changes produced by these and other causes increase the evil by causing stasis of alvine contents which afford more and more facilities for the increase of the toxins, and these are carried to the autonomous nerve centers establishing a vicious circle or syndrome. In its complete form it includes the secondary intestinal disturbances, abdominal pains, pressure on the nerve ends, the referred pains in other parts of the body, the nervous condition and neuropathic mental state and susceptibility to fatigue. Treatment may be in four forms according to the class of cases: (1) The skill of the internist, with all his resources to eliminate the toxins; (2) the physical culture methods such as the gymnastics, postural treatment, belts and corsets; (3) surgical treatment to restore normal condition, relieve obstructive angulation, false adhesions, and pressure and drag on the sympathetic ganglions, and (4) neurologic treatment to relieve the depressive emotional disturbances. The postural, gymnastic and corset treatment is an excellent prophylactic in early life for patients showing constitutional predisposition. The difficulty comes in in carrying the patient far enough to reach the sticking point where relapses may not occur. When the patient has reached the stage of actual ptosis of stomach and colon, and angulations have become obstructive and adhesions have formed, surgical treatment is the only resource. The extreme colectomy of Arbuthnot Lane is seldom necessary. Many other methods have been devised, none of which have stood the test of time and become standardized. Goffe does not discuss them, but describes a method of his own devising which he thinks has undergone a sufficient test to be worthy of consideration. His first case is described before the method is detailed in full. He first makes an incision below the umbilicus, corrects malposition of the lower viscera, separates adhesions, and then closes the incision. The second portion of the operation is described in full detail. The incision is made above the umbilicus and a thorough examination of all the organs is made, the incision being enlarged or new ones made as needed. The stomach is then delivered through the wound and, if dilated, the anterior wall is depressed with a sound and the stomach wall cutured over this. Sutures are placed, then, above or below this and midway between the stomach ends, and the stomach put back in place. The transverse colon is then delivered through the wound and sutures inserted in it in proper positions and drawn out through the same incision. The details of the method are best understood with the aid of the illustrations. Seventeen women have been thus treated and their cases are here reported, with fifteen satisfactory recoveries, one unsatisfactory, and one death. In that case there was a resection of about eight inches and an end to end anastomosis. Unfortunately the sutures did not hold, there was leakage and the patient died.

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Laboratory Tests.

A. B. Morrill, Chicago (Journal A. M. A., Sept. 28, 1918), describes the methods used in diagnosing contagious diseases at the base hospitals at the army cantonments. Cultures and cover glass smears are made from all sore throats for determining the presence of diphtheria bacilli, and where there are exudates showing diphtheria-like organisms, antitoxin is given at once. Other cases can wait until after cultures are made before taking antitoxin. Care is taken to separate patients showing diphtheria bacilli from scarlet fever cases, and for this purpose smears

are taken and cultures made in the receiving office. A Schick test should be made in all cases of sore throat, and is of value in differentiating true diphtheria from diphtheria carriers. The laboratory is also a convenient place for obtaining blood for routine Wassermann test, and has recently been of value in showing the frequency of the hemolytic streptococcus. A table is given showing the average white blood counts at admission. "These examinations led to the following general conclusions: Measles patients with counts of more than 10,000 and mumps patients with counts over 12,000 had a complication that demanded a careful diagnosis before they were sent to the wards. In a small series of nineteen cases, German measles averaged a higher count than true measles. Many mumps patients have a leukopenia of from 5,000 to 7,000. An orchitis elevates the white count in this disease by an increase of the monunuclear cells. There was little difference in the white counts in streptococcus sore throat and scarlet fever, although scarlet fever averaged slightly higher." There has been no difficulty experienced by laboratory examinations causing delay in putting the patients in their proper surroundings at Camp Grant.

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Preoperative Purgation.

The recent communication by Peet in The Journal, relating to the subject of catharsis before surgical operations, supplements the contentions of Alvarez of the Hooper Foundation for Medical Research that purgation as a routine preoperative procedure should be abolished. In his studies on the intestine, Alvarez had noted that after vigorous catharsis the isolated musculature is no longer as responsive as normally to stimuli and is fatigued with greater readiness. The bowel as a whole may become unduly filled with gas and fluid, the circulation of the intestine somewhat impaired, and the peristalsis deviated from its usual manifestations. In this way it was believed that much of the gas distention, post-operative ileus, and perhaps the nausea and vomiting may be partially accounted for in patients who have undergone surgical operations.

Peet has accentuated the difficulty thus encountered by asking what is expected to be gained through the preparatory evacuation. We suspect that most surgeons would be compelled to answer this query either by a meaningless platitude or by a confession of ignorance. The evidence for a need of or advantage in the customary "emptying" of the bowel by laxatives is, indeed, not easy to find. Sterilization of the interior of the intestine is out of the question as a practical possibility, and there is little indication that anything seriously toxic is removed by such catharsis. On the other hand, it is not unlikely, in view of these studies, that this procedure, attended by fatigue, and often by loss of sleep, is a positive detriment to the patient and an actual cause of some of the familiar postoperative discomfort, if this mild term sufficiently designates the distress referred to. Peet significantly comments on the uneventful convalescence of patients after emergency operations for which no preliminary therapy was instituted.

A further item is worthy of consideration in this connection. Catharsis leads to loss of water and intestinal secretion. If this is not compensated there may be distress from this cause. Crile has lately remarked, in reference to postoperative feeding, that even at this stage of medical knowledge the supreme value of water is not fully appreciated and its administration is often neglected or mismanaged. How much more serious is this incrimination when preoperative losses are freely induced by purgation. At most, therefore, Peet recommends simple enemas as a means of emptying the bowel before operation. If his contention is correct that, where the more drastic habitual procedure is abandoned, postoperative thirst, nausea and vomiting, abdominal distress and gas pains occur much less frequently, the appeal to abolish something sanctioned by custom deserves to be heeded.—Jour. A. M. A., July 27, 1918.

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Draft Revelations.

The following is taken from the reports of a statement made in New York by Dr. Livingston Farrand, director of the American Commission for the Prevention of Tuberculosis in France:

"How widespread the prevalence of tuberculosis is has been revealed to America more extensively than ever before as a result of the physical examinations made by the draft boards and army physicians. Approximately 40,000 men, it would appear from the statistics available, were rejected in the first draft as tuberculous. Many, if not most, of these men have been going about freely in the community not yet

aware that they were afflicted with the disease, and that they were sources of danger to others, especially children. Some have known that they had the disease, but have neglected their own condition and their responsibility as regards the health of their associates. Of the men who passed the draft boards, another 10,000, following more searching examination by medical officers of the army, were subsequently discharged on account of tuberculosis, giving a combined total of 50,000.

"While the war has thus effectually disclosed conditions which existed before, rather than produced these conditions, it is also true that in indirect ways it has substantially increased the tuberculosis problem in the European countries involved. I refer not to the situation in the armies where the mode of life often tends to reduce the extent of this disease, but to conditions which affect the civilian population. Increase in the price of food, clothing and housing, has exceeded general increase in wages. Consequently, among the lower wage groups who comprise the mass of the population, food supply has diminished in both quantity and quality. This has produced a state of undernutrition, which in turn has reduced physical resistance to tuberculosis, particularly among children. Among adults, mental stress and worry have lowered general vitality and increased susceptibility to the disease. These indirect effects of the war are clearly evident in France, and will doubtless become increasingly evident in America as the war continues."

Army Surgeon Finds Means to Combat Empyema, Strange Disease of Lungs, That Has Attacked Soldiers in Camp.

Official Bulleting August 15:

The War Department authorizes the following statement from the office of the Surgeon General:

By means of teamwork on the part of specialists, the Medical Department of the Army has now erected a dependable line of defense against empyema, the disease of the lungs that assumed the proportions of an epidemic in the camps and cantonments last winter, causing many deaths. The cause of the disease has been definitely ascertained and the best method of treatment established.

While similar epidemics have ravaged all armies for the last three centuries, at no time has the cause been known. The first known operation for empyema was performed in a similar epidemic during our War of 1812.

At the very inception of the epidemic Surgeon General Gorgas ordered special investigations to be made. Following this, the cause was discovered by an intensive study in the laboratory divisions of the bacteriology and pathology, the exact nature of the disease and the medical treatment outlined by the Army physicians, and the method of its spread determined by active work carried on by the medical department in every camp.

The Surgical Division was charged with the problem of devising the best method of treatment. To this end a special group, consisting of surgeons, internists, and laboratory workers, was located at Camp Lee, Va., where a large group of patients were available for study. At the same time empyema teams, consisting of a surgeon, a medical man, and a laboratory expert, were appointed from the staff of each base hospital to treat and make a special study of all cases at their particular hospital.

In civil practice the ordinary type of empyema is operated upon almost as soon as diagnosed. But today a patient in an Army hospital would probably not be operated upon until the primary acute infection had spent its virulence, as it has been found that this disease is entirely different from that met in civil life.

The medical officers feel that early operation may involve great risks without compensating benefits. The treatment carried out by the Empyema Commission consists of removing the pus by aspiration at as frequent intervals as necessary; that is, drawing off the fluid contained in the pleural cavity with the aid of a needle and suction apparatus. The laboratory

men on the commission proved that the virulence of the exudate usually decreased during the periods between aspiration; in other words, nature herself seems to take a hand. The medical officers have found that the best time to operate is when the general condition of the patient begins to improve. The operation is usually performed under a local anesthetic. In operations means are taken to prevent collapse of the lung. Many ingenious devices for the treatment of the disease have been introduced. In one hospital, where a ward was filled with patients suffering from empyema, the entire group of draining abscess cavities were attached by tubing to a central suction pump so as to keep the pus sucked out and keep the lungs of the patients expanded.

The following figures, taken from the report of the empyema team at the base hospital at Fort Riley, Kansas, demonstrate the effectiveness of t he new technique of treatment. From October 20 to January 29, eighty-five cases were under treatment which were not aspirated. Of these, fifty-two died. From January 29 to April 30, sixty-nine cases were being treated. All of these were aspirated. The deaths numbered six.

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Anaphylactic Shock.

L. F. Frissell, New York (Journal A. M. A., Aug. 31, 1918), reports a case of cerebrospinal meningitis with anaphylactic shock, treated by intraspinal administration of serum, which, however, failed to desensitize the patient, though she ultimately recovered. He thinks an error was made in the treatment by assuming that the intraspinal administration of the serum would necessarily desensitize, and in the future he would always administer the serum intravenously, by fractional doses.

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Syphilitic Reinfection.

Joseph Spangenthal, Buffalo (Journal A. M. A., Aug. 31, 1918), reports a case of syphilitic reinfection. The first appearance of the primary lesion occurred in September, 1913. The patient was a married man and had infected his wife. Both patients were treated by neosalvarsan and other specific treatment and recovered from this attack. At intervals of six months the patients reported for a Wassermann test which was always negative. In March, 1918, he developed another primary sore followed by secondary symptoms and two Wassermann tests were +++. This case seems to support the theory of the curability of syphilis, if it is admitted that it cannot recur in a cured case without having undergone complete recovery.

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Deterioration of Argyrol Solutions.

The manufacturers of argyrol advise that argyrol solutions be made freshly when required. The need for this precaution is confirmed by a report of work which indicated that the gonococcidal activity of an argyrol solution began to decrease a few days after it had been made and had decreased 75 per cent after two months. (Jour. A. M. A., Sept. 28, 1918, p. 1084.)

℞

Instability of Fluid Extract of Ergot.

There is some difference of opinion among investigators as to the keeping quality of fluid extract of ergot. However, it is clear that it loses its activity quite rapidly and may become inert within a year. (Jour. A. M. A., Sept. 28, 1918, p. 1084.)

℞

The Administration of Quinin.

From a study of the elimination of quinin in different diseases, it appears that for optimal effects it is best in most cases to give quinin every three or four hours in approximately 0.25 gm. doses, preferably by mouth except when there are gastro-intestinal disturbances, and here subcutaneous or intramuscular injection is indicated. Needless to say, the daily 2 gm. should be exceeded in cases of pernicious and primary malaria. The intravenous method should be employed in pernicious cases. (Jour. A. M. A., Sept. 28, 1918, p. 1086.)

℞

Epididymitis.

R. L. Cook (Washington, D. C.), Fort Sam Houston, San Antonio, Texas (Journal A. M. A., April 6, 1918), considering only subacute and acute gonorrheal epididymitis, on the basis of his experience with 276 patients since entering on his work at Fort Sam Houston, combats the upholders of non-operative treatment in this disease. The almost immediate relief from pain,

which follows operation, would alone justify it, and the beginning hydrocele which accompanies it is also relieved. He concludes also that the operation and discharge of pus which occurred in thirty-three of his cases is more apt to save the function of the organ, than are palliative measures. The breaking up of the adhesions to the parietal layer of the tunica vaginalis is most essential, and is best done with the finger and a piece of gauze. Any lymph collecting between the layers of the tunica vaginalis should be removed with the gauze. He describes the technic of the operation, which should be done in all cases, and says he has had only one case not attributable to gonorrhea. His results have been uniformly favorable.

Carbon Monoxid Poisoning.

W. D. McNally, Chicago (Journal A. M. A., November 10, 1917), says that deaths from carbon monoxid poisoning now exceed in number all others in large cities. While it may occur in various occupations, the greatest percentage of carbon monoxid asphyxiation is through illuminating gas. Its odor does not prevent a large number of accidents because it may not be noticed by persons in deep sleep or those with a defective sense of smell. The proportion of carbon monoxid differs greatly in domestic and industrial gases, varying between 4 and 10 per cent in coal gas, 30 per cent in water gas, and 20 to 30 per cent in producer gas. An atmosphere containing 0.2 per cent is capable of destroying life. It is commonly believed that the percentage of carbon monoxid increases during the winter months, but this is not the case. The more extensive use of it during the cold weather is the real cause of the greater frequency of accidents. It combines chemically with the hemoglobin of the blood to form a stable compound. It does not directly kill the blood corpuscle. All it needs is oxygen under sufficient tension to displace the carbon monoxid. Hemoglobin will take up more carbon monoxid if a little oxygen is present than if it is absent. People near open doors or windows suffer the least from escaping gas and those nearest the floor the most. Exposure for two or three minutes may cause serious illness. An exposure of ten minutes in a cellar has been known to kill a person. In most cases the victims are found dead, or they die in a short time. For medicolegal purposes it is of the utmost importance to show the source of the poisoning which may frequently be found in an open gas jet, defective joints or rubber communicating tubes. At the present time there are no good analytic methods for distinguishing the poison of illuminating gas from that of coal gas or other sources. The time required completely to eliminate the poison from the blood has not yet been definitely determined, as it varies greatly in different persons. The writer gives the tests for carbon monoxid, such as the use of birds in coal mines and the examination of the blood, but asserts that if positive results are obtained with the tannic acid, the basic lead acetate and the paladium chlorid test, all other tests may be considered superfluous. Two tables accompany the text.

Dr. R. B. H. Gradwohl, director of the Gradwohl Biological Laboratories and the St. Louis Pasteur Institute, of St. Louis, Mo., has recently been honored with the position of Organizing Director of Naval Base Hospital, Unit No. 19, with the rank of Lieutenant Commander. Realizing fully the fact that these laboratories are fulfilling a great national duty in caring for the wants of physicians, Dr. Gradwohl will leave his splendid organization in full working order under competent direction during his absence. The physicians who have honored these institutions with their work may continue to send it with full assurance that their every want will be carefully and conscientiously looked after.

Reconstruction of the Common Bile Duct.

J. S. Hohsley, Richmond, Va. (Journal A. M. A., Oct. 12, 1918), says that since excision of the gallbladder has become more frequent, the possibilities of injuring the common bile duct have multiplied. After reviewing the methods that have been suggested for its repair, he says that it occurred to him that the transplantation

of an everted vein might be successful, and he points out its theoretical advantages, such as the endothelial coat outside offering better chances of nutrition and the general probable lines of growth that might form a satisfactory duct. These theoretical advantages were not borne out by his experimental work on sixteen dogs, and the practical conclusion from these experiments seems to be that while such reconstruction is possible the outcome is unsatisfactory. The contraction of the reconstructed duct from the continued irritation of the bile tended to an ultimate occlusion by prolonged infiltration with inflammatory products. Horsley's conclusion is that the repair of any structure over which irritating discharges flow should be by means of tissues that are either wholly or partly immune to these discharges. It seems to him that the most satisfactory reconstruction occurs when the stump of the common or hepatic duct is sutured to the mobilized mucosa and submucosa of the duodenum. In this way epithelial and subepithelial layers of tissue accustomed to the biliary discharge are employed, and if accurately approximated, the corresponding tissues unite without necessarily causing contraction any more than would suturing a wound in an intestine. Such a technic has been employed by Dr. W. J. Mayo, and similar work has also been reported recently by Dr. Le Grand Guerry.

———R———

Bacteriology of Measles.

Ludvig Hektoen, Chicago (Journal A. M. A., Oct. 12, 1918) gives a critical review of the literature of the micro-organisms of measles. The records of finding protozoa are few and largely unconfirmed. Under the head of miscellaneous come observations so fragmentary and inconclusive or made with such comparatively crude methods that they now seem of little or no value. Still this type in the literature is reviewed, apparently quite thoroughly. The principal bacilli that have been described can be roughly grouped under the heads of diphtheroid or influenza-like bicilli. The literature of this subject is pretty extensively gone over by Hektoen, as is also that of coccal infections, which play an important part in the complications and after effects. Hektoen says that the chief bacteria concerned with measles as at present known are: (1) The coccus found by Tunnicliff in the blood early in the attack and also in the throat and nose; (2) influenza bacilli, and (3) hemolytic streptococci. As opsinins and probably other bodies specific for the Tunnicliff diplococcus reach the blood in the course of the measles attack, this coccus must be of some significance, but the exact significance we have still to learn. While hemolytic streptococci seem to predominate overwhelmingly in the bronchopneumonia, their active part in the measles should be studied further, since they may spread rapidly among measles patients and largely, it would seem, by throat and droplet infection. The best way at hand to avoid serious complication of streptococcic pneumonia is early isolation of the patients to protect others against infections, including fellow patients, that may harbor streptococci. Such isolation protects against other infections also. The possible danger of streptococcus infection by food is not to be overlooked. Finally, it is evident that the immunology of the streptococci concerned, their unity or plurality, their changes in virulence, and other problems require still more investigation.

———R———

Blood Cultures in Pneumonia.

J. E. McClelland (Cleveland), Camp Beauregard, Alexandria, La. (Journal A. M. A., Oct. 19, 1918), emphasizes the importance of blood cultures in pneumonia as shown by his experience in Camp Beauregard. He says: 1. Blood cultures in pneumonia are valuable from the standpoint of prognosis and as a guide in the serum therapy of the Type I cases. 2. Septicemia is more common with the more virulent strains of pneumococcus and with streptococcus hemolyticus. 3. Type I pneumococcus septicemia responds very promptly to immune serum treatment. 4. A moderately severe Type IV pneumococcus septicemia may be quickly recovered from. 5. The mortality in hemolytic streptococcus septicemia is very high, but one case is reported in which the patient had a slight transient septicemia and recovered."

———R———

Sure Cure.

Doctor—You are suffering from nervous prostration. Buy a ticket for California.

Patient—Doctor, I can not leave my business now.

Doctor—You don't have to. Give the ticket to your wife.—St. Louis Globe.

———R———

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EDITH GLASSCOCK, B.S.
Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

Italian Medical Service.

R. B. Cofield, Cincinnati (Journal A. M. A., Oct. 19, 1918), says that the infection of the knee joint is one of the most serious that the surgeon has to meet, and he describes his method of treating this based on the results achieved in the present war. The favorable results seem to depend on the following general principles: 1. The operation must be done early before there has been time for disintegration of the joint structures. 2. There must be thorough lavage of the involved areas followed by primary closure of the joint capsule. 3. Foreign bodies must not be allowed to remain within the joint cavity. 4. If drainage is used it should be carried to the joint capsule but not into the joint cavity. 5. Immobilization of the joint must be secured by adequate mechanical fixation. The cytologic investigation of the joint fluid is a distinct aid to the diagnosis, and at times to the prognosis. Cofield describes his method, which is based on the above mentioned principles. He prefers to use an active disinfectant that is penetrating as well as cleansing. Mercuric chlorid, 1:15,000, in salt solution at a temperature of about 115 F. and followed by physiologic sodium chlorid solution has proved very satisfactory. It is very important that flexion and extension of the joint should be passively carried on while the cavity is being flushed. After the operation the limb is placed in a position of physiologic rest, allowing active motion once or twice a day guided by the sense of pain.

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(1941)

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC.

Required by the Act of Congress of August 24, 1912, of the Journal of the Kansas Medical Society Published Monthly at Topeka, Kansas, for October 1, 1918.

State of Kansas, County of Shawnee, ss.

Before me, a notary public in and for the state and county aforesaid, personally appeared W. E. McVey, who, having been duly sworn according to law, deposes and says that he is the editor of the Journal of the Kansas Medical Society and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in Section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:
Name of Post Office Address
Publisher—W. E. McVey, under direction of the Council of the Kansas Medical Society .....Topeka, Kansas
Editor—W. E. McVey.....Topeka, Kansas
Managing Editor—None.
Business Manager—None.

2. That the owners are: (Give names and addresses of individual owners, or, if a corporation, give its name and the names and addresses of the stockholders owning or holding 1 per cent or more of the total amount of stock.)
Kansas Medical Society, Dr. W. S. Lindsay, Topeka, President; Dr. J. F. Hassig, Kansas City, Secretary; Dr. L. F. Barney, Kansas City, Acting Secretary; Dr. L. H. Munn, Topeka, Treasurer.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only).

W. E. McVey, Editor.

Sworn to and subscribed before me this 26th day of September, 1918.

R. A. Ferlet,
(Seal) Notary Public.
(My commission expires February 20, 1920.)

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, DECEMBER, 1918 No. 12

The Preparation of Laboratory Specimens and the Interpretation of Laboratory Reports.

WILBUR A. BAKER, M.D.

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Since the campaign of the United States Public Health Department against venereal disease and the opening of the Kansas Public Health Laboratory at Rosedale will place every general practitioner in closer touch with the laboratory, it seems that a few brief concise instructions relative to the preparation and shipment of specimens for laboratory examination might be in order. This article will be confined to the discussion of specimens commonly sent in by the general practitioner. About the greatest bug-bear to the average laboratory is the busy clinician who does not take the time or trouble to properly prepare his laboratory specimens or send adequate data with them. In order for the clinician to secure the most reliable results and the greatest possible assistance from the laboratory it is not only necessary for the pathologist to use the greatest care in his technic, but careful technic must begin with the clinician when he secures the specimen. Another fact which seems rather hard to impress upon the mind of the average clinician is that a specimen must be accompanied by a brief clinical history of the case if the pathologist is to render an intelligent report. This is especially true when bits of tissue are sent in for examination.

BLOOD FOR THE WASSERMANN TEST.

In obtaining blood for the Wassermann test the two most important things to bear in mind are that sufficient blood must be obtained and the blood must not be hemolyzed when it reaches the laboratory. In order to help eliminate this danger of hemolysis the Public Health Department has adopted a mailing outfit containing two vials so that the serum can be separated from the corpuscles before it is mailed to the laboratory. Care should be taken not to moisten or contaminate the vials before use, as a very small amount of water will cause hemolysis. Alcohol or other chemicals should never be used in sterilizing any instruments used in obtaining the blood. The outfit furnished by the Department contains a sterile needle for drawing the blood, but shoud the operator prefer he may use a 10 c.c. Record or Luer syringe and a 21-gauge needle, but these instruments must be sterilized by boiling in normal salt solution (0.85%).

The following points should also be borne in mind: (1) Blood should not be collected within two hours after a meal. (2) The ingestion of alcohol within twenty-four hours previous to taking the blood weakens the reaction and is apt to give rise to a false positive. (3) An anesthetic within twenty-four hours previous to taking the blood is apt to give rise to a false positive.

In adults blood is usually easiest obtained from one of the cubital veins, or if these are too small one of the veins of the leg may be used. In young children it may be obtained with a syringe from one of the external jugulars, or from the anterior fontanelle in infants. Since there may be some who are unfamiliar with the

technic of vena puncture, a brief description of this technic will be given.

A rubber tourniquet or bandage is fastened about the upper arm tightly enough to constrict the veins and make them stand out distally, but not tightly enough to cause disappearance of the radial pulse. The patient is then told to open and close his hand several times, and if this does not make the veins stand out sufficiently, the arm may be hung down and the cubital space slapped briskly with the palm of the hand. The skin over the veins is cleansed with soap, alcohol, and then ether, and the most prominent vein selected. Tincture of iodine may be used for sterilizing the surface, but is open to the objection that it tends to obscure the vein, and many patients will object to its use. Puncture is usually made eaiest just opposite the bend of the elbow. The patient's arm is grasped firmly in the left hand of the operator so that the thumb of the operator rests on the vein at a point about one inch below where the puncture is to be made, exerting pressure and slight traction distally on the vein and thus preventing its slipping away from the needle. The needle is then so directed that it makes an acute angle with the forearm and plunged into the vain. If the needle is entered perpendicularly to the surface of the skin, it is apt to go entirely through the vein, resulting in a hematoma and considerable difficulty in obtaining the desired blood. When the needle has entered the vein the point of it is free, meets no resistance, and the blood soon begins to flow. The blood is allowed to flow into the larger of the two vials until it is nearly full, or if a syringe is used, gentle aspiration is made until at least 8 c.c. of blood is obtained, which is immediately deposited into the large vial. When the desired amount of blood has been obtained the tourniquet is loosened, the needle withdrawn and pressure made over the point of puncture for a few minutes with a pledget of sterile cotton or gauze.

After the blood has been secured, support the vial in an inclined position so that the surface of the blood almost but not quite touches the cork. When coagulation is complete loosen the clot from the walls of the vial by passing a sterile wire or needle around the clot just inside the glass. Allow the vial to stand in a cool place for about twelve hours, or until sufficient clear serum has separated out. At the end of that time pour the clear serum gently into the small voal, leaving the clot and corpuscles in the larger one. Both vials should be corked, labeled and mailed in the double container furnished by the department.

CEREBRO-SPINAL FLUID

If only a Wassermann test is desired on the cerebro-spinal fluid, it may be allowed to flow directly into the larger vial when the lumbar puncture is made. It is then labeled "spinal fluid," marked with the patient's name and sent at once to the laboratory.

If, however, a colloidal gold test is desired, the cerebro-spinal fluid must be free from blood and the vials free from albumen. A special technic is therefore required in preparing the vials. A very satisfactory method is as follows: The vials are washed thoroughly with distilled water, then with 95 per cent alcohol, then rinsed with ether and the ether burned out by holding the vial in a forceps and passing it through a flame until it is thoroughly dried and sterilized. The corks are then replaced and the vials are ready for use. When the lumbar puncture is made the first few c.c. of the spinal fluid is allowed to flow into the larger vial and this labeled Specimen No. 1. This specimen is the one most likely to contain blood and can be used for the Wassermann test, and at least 5 c.c. should be collected in this vial. The smaller vial is reserved for the last two or three c.c. of spinal fluid drawn, as this is less likely to contain blood. It is labeled Specimen No. 2. Both vials are tightly corked, marked with the patient's name and mailed at once to the laboratory.

PUS SMEARS FOR THE GONOCOCCUS.

In acute cases of gonorrhea there is usually little trouble in obtaining suffi-

cient pus for smears or in finding the organism in the smears. In the chronic cases, however, the task becomes infinitely more difficult for both the clinician and the pathologist.

Smears should never be made less than three hours after urination, and in the female the use of douches should be discontinued for at least three days before taking smears. The technic for making smears will be described for male and female paatients.

Male: Cleanse the meatus with soap and rinse well with water. It is important to have the parts clean in order to avoid contaminating the smear with the secretion and many organisms always found around the glans penis. Squeeze the penis so as to milk out the pus from the penile portion of the urethra. When sufficient pus presents at the external orifice of the urethra, collect it on a clean cotton swab and make a smear on a microscopic slide by making a single stroke across the glass with the swab. The smear should be thin, evenly spread, and cover about one-half the surface of the slide, but do not rub the swab back and forth or around and around over the same area, as this destroys or distorts the pus cells so that they do not stain properly and identification of the organisms is difficult or impossible. Allow the smears to dry in the air, label with patient's name, place them film sides together, wrap with paper and mail to the laboratory. Submit at least two smears from each case.

If the case at hand is a chronic one and little or no discharge can be obtained by squeezing the penis, provocative treatment should be tried. For several days before taking the smear have the patient eat the stimulating food previously interdicted and take active exercise. If discharge is entirely absent, pass a mediumly large sound about twenty-four hours before taking the smear. The use of irritating injections such as 0.5 per cent silver nitrate is also of value. When the patient presents himself for examination, massage the prostate and seminal vesicles thoroughly with the patient standing but bent over and the penis pendant. Collect the discharge resulting from the massage and make smears as previously described. Then have him pass his urine into a sterile bottle and send the urine sample and the slides to the laboratory with a statement of the nature of the examination desired.

Female: Wipe off the external genitalia with a piece of dry gauze and with the finger milk out the pus from the urethra and make smears on two slides. Examine the glands of Bartholin and if they show signs of inflammation, express some of the secretion and with a fresh swab make smears from it. Next insert a speculum and with a fresh swab collect some of the secretion from the inside of the cervix and make smears on two slides. Label all slides with patient's name and source of smear. Do not submit vaginal smears, as their examination is not worth while.

SMEARS FOR TREPONEMA PALLIDUM.

Treponema pallidum can often be found microscopically in material from hard chancres or mucous patches if the specimen is properly collected and stained. The treponema pallidum, being an anaerobic organism, will not be found in the superficial secretions, but serum from the deeper part of the lesion must be obtained. This can usually be accomplished by rubbing the lesion briskly with a rough piece of gauze, avoiding bleeding as much as possible. A thin smear is then made from the sanious oozing by collecting some of the serum on the surface of a slide near the end and spreading it with the edge of another slide or with a cotton swab. In some cases it may be necessary to curette the lesion in order to secure sufficient oozing. Allow the smears to dry in air without the application of heat. Submit at least two smears.

BLOOD SMEARS FOR MALARIAL PARASITES, LEUKEMIAS, ETC.

Malarial parasites are more easily found and identified if the blood is collected shortly before a paroxysm is due. The first essential for a good blood smear is a slide that is absolutely clean and free

from any oily substance. This can be accomplished by cleansing the slides with soap and then with acid alcohol. Blood may be obtained from the lobe of the ear or a finger. Cleanse the skin with alcohol and then with ether, rubbing briskly to stimulate the circulation. Puncture with a sterile needle or lancet so that the blood flows freely and does not require compression of the part. Wipe away the first drop of blood, and the drop to be used should be only a little larger than a pin head. Touch the drop of blood with the flat surface of a slide near one end and place the slide in such position that the blood is on the upper surface. Then place the edge of a second slide on the surface of the first at an angle of 30 to 45 degrees and draw it back into the drop of blood so that the blood distributes itself in the acute angle between the two slides. Then move the second slide forward with a sweeping motion and the blood is drawn along by capillary attraction, making a thin film over the first slide. Several smears should be made from each case. Failure to find the organisms does not by any means mean their absence in the patient.

BLOOD FOR WIDAL TEST.

Use same technic as in procuring blood for Wassermann except that one or two c.c. is sufficient for the Widal test.

SPECIMENS OF TISSUE FOR EXAMINATION.

In the taking of diagnostic sections of tissue for examinataion considerable judgment and skill is sometimes required to secure a piece that is representative of the pathological condition present. This is especially true in taking diagnostic sections from tumors. The tissue should be taken from the border of the tumor if possible, for it is here alone that the true nature of the tumor can be determined in all cases. The tissue is placed at once in 4 per cent formaldehyde solution (10 per cent formalin) and by the time it reaches the laboratory it will be fixed sufficiently for frozen sections to be made. A statement of the location of the lesion and a brief description of its appearance, duration, etc., should always accompany the specimen. In the examination of bits of tissue the clinician is justified in asking the pathologist for a diagnosis in most cases, providing he has supplied the proper data and the specimen was properly taken.

RABIES OR HYDROPHOBIA.

Heads of animals to be examined for rabies should be shipped to the laboratory as quickly as possible after the animal has died, and if the weather is warm the head should be packed in ice. Dogs should never be shot through the head, as any bad laceration of the brain may make the search for Negri bodies difficult or impossible. It is always much better to shut the suspected animal up and watch it than to kill it at once, for if it has rabies it is sure to die in a few days and the head can then be sent in for examination. The Negri bodies are sometimes very difficult to find, and if the animal died with the symptoms of rabies it is well to recommend the Pasteur treatment, even though the laboratory findings should be negative. The treatment is harmless and there is too much at stake to take chances.

INTERPRETATION OF LABARATORY FINDINGS.

In the interpretation of laboratory reports the most important thing to be remembered is that the laboratory report is only a help to the clinician in making his diagnosis. It constitutes only one link in the chain of facts. A common mistake of the practitioner is to imagine that it is the pathologist who is diagnosing the case, and to allow the laboratory report to override every other piece of evidence which may have been gathered. It is true that the laboratory evidence very often does decide the question and decide it correctly, but it would be a very serious mistake to think that it dispenses with clinical examinations.

In case the laboratory and clinical findings do not agree, another specimen should be submitted at once to the laboratory and further measures taken to find the reason for disagreement. The clinician should never allow a negative laboratory report to swerve his opinion too strongly. All

negative reports are of rather limited value.

WASSERMANN REPORTS.

In the interpretation of Wassermann reports it should be kept in mind that the Wassermann test is a test of the patient's resistance to the disease. Consequently some cases, in which for some reason the patient has not developed anti-bodies in his blood, may show a negative test although the patient may have the disease. A negative report is therefore not of great value in excluding syphilis, since there is practically no stage of syphilis in which 100 per cent of positive reactions are obtained.

A four plus (frankly positive) or a three plus test is reasonably certain evidence that the patient has syphilis in an active form. Any reaction less than three plus should not be regarded as of any very great diagnostic value unless accompanied by clinical evidence. In a known case of syphilis that has had antisyphilitic treatment the weaker positives should indicate the necessity of further treatment.

The percentage of positives is probably smallest in the early stages (primary) of the disease. The highest percentage of positives on blood is obtained during the secondary stage. In the tertiary stage the percentage of positives again drops, and not infrequently one finds a case showing a very active tertiary lesion and a negative Wassermann. In syphilis of the central nervous system the Wassermann test is often negative on the blood, although the spinal fluid almost always shows a positive test. Many cases of hereditary syphilis, especially of the latent type, give negative Wassermanns.

Specific treatment influences the reaction temporarily, independent of the success of the treatment, mercury and potassium iodid tending to make the reaction temporarily negative, Arsphenamine tending to make mild reactions temporarily stronger. This fact is made use of in the so-called provocative test, which is very useful in cases with lowered resistance that give negative Wassermanns. In this test the patient is given a small dose of Arsphenamine (0.3 gm.) and about seven days later another blood specimen is taken for examination.

CEREBRO-SPINAL FLUID TESTS—CELL COUNT.

Normal cerebro-spinal fluid should not have more than about five cells per cu. mm. In tabes dorsalis and general paresis the count is often increased to 50 or 100 cells. In cerebro-spinal lues the count may go as high as 1,000 per cu. mm.

COLLOIDAL GOLD TEST (LANGE'S).

It is now pretty generally accepted that this test is more diagnostic of general paresis than any other single test. In this disease the change takes place in the first five tubes and this is called the "paretic curve." In cerebro-spinal lues the change is most marked in the third, fourth, fifth and sixth tubes. In various types of meningitis other than Luetic the changes are usually most marked in the sixth to the tenth tubes.

The degree of change in each tube is designated by a numeral, ranging from 0 to 5, 0 meaning no change and 5 the strongest change. Example of reading: 0 1 3 4 5 4 2 1 0 0. Here the greatest change is in the fifth tube and this is a paretic curve.

GLOBULIN TEST.

A positive Butyric Acid test (Noguchi) or Nonne test means an increase in the globulin content and is usually present in syphilis of the central nervous system.

PUS SMEARS FOR THE GONOCOCCUS.

The finding of a "gram negative intracellular diplococcus" is practically certain evidence that the organism is a gonococcus. If the material is from the genitals of the male or female, the chance of such an organism being other than the gonococcus is very slight indeed. The finding of a "gram negative extracellular diplococcus" indicates that the organism is probably a gonococcus, but there is a possibility of its being some other organism, especially if the smear is from a female. A simple "negative" report indicates that no organism was found that resembled the gonococcus. Failure to find the gonococcus by

no means indicates its absence in the patient. In chronic cases of gonorrhea the percentage of negative smears will run very high.

TREPONEMA PALLIDUM.

Finding the treponema in a smear or bit of tissue from a lesion is positive evidence that the lesion is syphilitic and very highly infectious. Failing to find the treponema is practically of no value in excluding syphilis.

Spanish Influenza at the University of Kansas.

NOBLE P. SHERWOOD

From the Department of Bacteriology, University of Kansas.

It is a rather interesting fact that the epidemic of Spanish influenza began in Lawrence coincidently with the assembling of students at the University of Kansas. The first cases which came under observation of the University Health Department were some six in number at one of the fraternity houses. This was about September 25, 1918.

At the very beginning of things there was considerable uncertainty as to what should constitute a diagnosis of the disease. The State Board of Health and the city health officer requested the co-operation of the Department of Bacteriology. Accordingly nose and throat examinations were made in a series of suspected cases and contacts. The results obtained were similar to those obtained at Fort Riley and other cantonment laboratories; *i. e.*, nothing abnormal as to types of bacteria found.

As we look at it now, there was a lapse of some two weeks from this time during which period only a comparatively few isolated cases appeared. About October 5 several cases of suspected influenza were found among the members of the S. A. T. C. The commanding surgeon asked and received co-operation from the Department of Bacteriology in determining whether these were ordinary colds or true influenza. About the only laboratory findings that seemed to be of value were blood counts, as leucopenias were being quite uniformly reported in Spanish influenza cases. Accordingly, twenty blood counts were run on October 5. These showed leucopenias quite uniformly. The commanding surgean, Dr. J. S. Allen, was quite sure that clinically they presented the aspects of influenza and the blood counts seemed to verify the clinical pictures.

In view of the fact that statistics showed that usually about 40 per cent of the military population came down with Spanish influenza during an epidemic, it was quite apparent that, potentially, there was reason to expect some 700 or 800 cases during the next few weeks. Fortunately one of the barracks was nearly complete and could be used for a hospital. The commanding surgeon immediately asked the Chancellor and Dean of the Medical School for assistance. Volunteers among the senior medical students were called for and within six hours, eight senior medical students and three nurses arrived from the University Medical School at Rosedale and the remainder of the senior class came down the following day. The Chancellor's office also obtained the services of an experienced superintendent of nurses to act as head nurse. Within the next twenty-four hours the city health officer had obtained the services of twelve graduate and undergraduate nurses to assist with the work. As further help seemed necessary, the Dean of the Medical School asked for volunteers and obtained the services of practically every junior, sophomore, and freshman medical student enrolled in the University. In addition, the services of two graduate physicians on the faculty at Lawrence were offered and accepted by Dr. Allen.

A large number of women and men of the University faculty and students of the University offered their services. Some of these acted as nurses and nurses' aids; others took charge of the linen room. The women of the faculty installed a diet kitchen to handle food for the patients, and many students and women of the fac-

ulty served faithfully and efficiently in this work. At the same time the local Red Cross met in one of the University buildings and supplied the demand for masks to be worn by all employes and nurses at the hospital. The administrative officers of the University actively co-operated with the Red Cross in obtaining linen and clothing to meet the emergency. The local physicians and a physician from Leavenworth responded to the call and faithfully assisted with the work at the barracks hospital. Five medical officers from Ft. Riley were dispatched to Lawrence in time to co-operate with those already on the ground.

Mr. Joseph Welker, assistant professor of physiology now in the service, worked with untiring energy in helping to perfect the organization. He ably assisted Dr. S. J. Crumbine in planning for a pneumonia hospital to accommodate twenty patients.

The Department of Bacteriology was privileged to organize a laboratory in the barracks hospital. This was operated on a twenty-four-hour basis and took care of the laboratory work requested by the hospital staff. The entire department, several of its present as well as former students and a member of the Department of Zoology, applied themselves to this work.

In all, some 850 cases of influenza developed. As complications it might be of interest to note that sixty-five cases of pneumonia and eight cases of pneumococcus meningitis occurred. There were in all thirty-two deaths. A tribute should be paid to the senior medical students who volunteered as a class to assist in this work. One of their number, Mr. Hepler, made the supreme sacrifice, and two others came down with Spanish influenza.

In regard to the comparatively low death rate, it might be noted that it was not necessarily due to a lack of virulence of the infectious agent concerned, but it is quite as likely due to the following reasons:

1. Immediately upon the breaking out of the epidemic the men were all issued an abundance of blankets.

2. The barracks hospital was exceptionally well ventilated.

3. A two hundred bed hospital was organized within ninety-six hours and accommodations for 500 men within the week.

4. Physicians and nurses and other assistants were quite amply provided within twenty-four hours after the outbreak of the epidemic.

5. Of equal importance was the establishment of a splendid pneumonia hospital.

6. The quite rigid enforcement of a fairly long period of rest and observation following apparent recovery.

The commanding surgeon has asked me to express his appreciation of the co-operation of the University as a whole, and the Medical School in particular, in assisting the medical corps in handling the epidemic.

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Early History of the Medical School of Kansas.

L. E. Sayre.

In 1885, by action of the legislature, the School of Pharmacy was created as one of the departments of the University of Kansas. The writer was chosen by the Board of Regents to act as head of the department. Coming from Philadelphia, where he had been as instructor and interested in and having connection with medical education, it was but natural that he should be vitally interested in the creation and development of a school of medicine in connection with the University of Kansas, whose charter anticipated and provided for such a school. Arriving at the University in the fall of 1885 it was found that, in connection with Chemistry, there was taught subjects relating to medical chemistry. There was a small exhibit of medicinal chemicals and crude drugs. Professor Bailey, inspired with the idea that the future had in it possibilities of a medical school worthy of the name, had continued the work of his predecessor, Professor Patrick, in keeping intact the faintest beginning of what might, even

then, be called a premedical, or preparatory, medical course. The writer was asked to give courses in physiological chemistry and materia medica to these preparatory students. After a course had been outlined for these students, it was submitted to the medical schools in the East (Pennsylvania, Jefferson, Rush and others) who, for the two years' work as outlined gave a credit of one year toward a regular medical course. In the course of a few years, it is well known, the time came in medical centers to thoroughly test medical education and check up its "Airy Conceit," as it were. From this test, or investigation, it became evident that better equipment, larger instructional forces and personnel were necessary to meet the demand of the times. Fortunately, at this time there had been elected to the University staff of instruction Dr. S. W. Williston—one who was found to be quite equal to the occasion. Dr. Williston said all the conditions required for medical education must be met or complied with at whatever cost. Dr. Williston at once put in operation a two years' course which should properly connect with the best medical colleges for credit. This was accomplished. Subsequently, on the advice of the medical profession and institutions of the state, a full four years' course was established. Dr. Williston, however, being called to the University of Chicago, was obliged to leave the development of this final stage of what was in early days an ideal conception, the real thing—a medical school of the University of Kansas. Such is a brief recital of many years of work from the early insignificant beginning. Looking back over a period of over a quarter of a century and noting the many obstacles which the school has had to face and overcome, it is surprising what progress the school has made with so many odds against it.

In connection with this history, which would be quite incomplete were it not mentioned, it should be noted that among its warm friends and ardent supporters was Gov. Robinson, who looked upon this initiatory period as very important for the State of Kansas and frequently expressed his desire that the foundation of this preparatory work would lead to what it has finally attained. This particular phase the writer would like to emphasize, *i.e.*, the connection of Dr. Robinson and his expressed wishes concerning the school. Dr. Robinson has mentioned a number of times that it was his desire to aid in the establishment of a medical school when the time should be right for that. Unfortunately, Dr. Robinson passed away some years before the time that the real medical school was announced in connection with the University. In his bequest to the University it was a disappointment to the friends of the medical school that he did not mention in this the desire he had so frequently expressed during his life. Intimate friends, however, felt assured that when the appropriation of this bequest should be made it would go in the direction of what seemed to be his epressed wish during his life.

It was during the administration of Hon. E. T. Hackney, who was president of the State Board of Administration, that I was asked by him to put upon record, as the one member of the faculty who knew Dr. Robinson, statements regarding his expressed wishes.

In response to this request the following letter was addressed to Hon. E. T. Hackney, October 21, 1916:

Hon. E. T. Hackney, President State Board of Administration, Topeka, Kansas.

My Dear Mr. Hackney: Permit me, as a friend of Doctor Robinson, to entreat you, as representing the University of Kansas, to use your influence to see that the wish of Governor Robinson, as expressed to me in the presence of Doctor Snow and Noble Prentiss, is carried out.

When I took the Chair of Pharmacy at the University of Kansas, steps were immediately taken to have the work done in the School of Pharmacy accredited as one year's medical work toward the medical degree in the principal medical schools of the East, namely, the University of Pennsylvania, Jefferson Medical College, Rush Medical College, etc. This credit was granted by these institutions. Thus was established a nucleus of a medical school.

Knowing of this effort, Governor Robinson took an interest in the Department and the Dean and because of this, perhaps, became friendly, and, as a friend, talked freely of his lifelong interest in medicine and his desire that this nucleus should grow into a recognized medical school.

Doctor Robinson's early life was associated in medicine with Doctor Holland of Springfield, Massachusetts. Mr. Paul Brooks of Lawrence has a portrait of Doctor Holland just as it always hung in Doctor Robinson's home.

On several occasions Doctor Robinson talked with me about the proposed medical school and how it might be developed. One of the occasions which indelibly impressed itself upon my mind was at the time of the University's quarter-centennial celebration when Dr. Snow and Noble Prentiss and his wife, who were our guests, were invited with a few others to the Robinson farm for the day. While there, Doctor Robinson talked freely of what he had in mind for the proposed medical school. It was after dinner on the lawn this conversation took place. During his talk he distinctly stated he intended to bequeath a substantial sum for the medical school at the University if the University should see its way clear to make such a school possible. Very respectfully yours,

(Signed) L. E. SAYRE.

That the Medical School is in great need of such help as the Robinson estate would give is a question no one would doubt who is at all acquainted with medical education. The present time is one of the most critical for our state school in that, to retain its high standard (Grade "A") it has hitherto enjoyed. To keep this standard it must advance and increase in facilities, keeping pace with the average demands required by American medicine. One of the essential things to be met at once to this end is the erection of a medical building on the University grounds on Mt. Oread. The setting aside by the legislature of the present "Robinson Estate" for the specific purpose of a medical laboratory building would seem to the writer and other friends of Dr. Robinson not only appropriate but essential.

The Medical School, the Profession, and the Public.

MERVIN T. SUDLER, Ph.D., M.D.

Associate Dean, the School of Medicine, University of Kansas.

The relation of the Medical Department of the State University to the medical profession should be one of mutual co-operation and help—in fact, a relation somewhat similar to that which the Agricultural College has established between itself and the farmers of the state. In this instance the farmer can get special training by attending suitable courses. He can also get literature, advice, and information that will help him solve his problems at home.

The Medical School, in addition to training men to practice their profession and supplying them to the population of the state to replace those who move away, or retire, or who die, has tried to make itself generally useful to the profession; though its facilities have not been sufficient to realize this to the fullest extent. It should do this by giving physicians an opportunity for advanced study in the laboratories and clinics; so that the physicians in general practice, as well as one who is practicing a specialty, may get a chance to keep pace with the advancements in medicine with a minimum of effort and expense. The use of its library, both at Rosedale and at home—by means of sending literature on any subject upon request—has been utilized to a considerable extent. As far as possible, the school should aid in complicated laboratory methods of diagnosis; particularly, in contagious cases where the health of the public is concerned. A full measure of usefulness can be obtained only by mutual co-operation and suggestion on the part of the profession of the state and the school. For several years now there has been a committee appointed by the President of the State Medical Society to visit the school and make suggestions that would tend to increase its usefulness to the profession and the general betterment of the school. So far, no results have come from this effort. However, it is still pos-

sible, as the interest in the school may increase so that the committee may become more active and greater efficiency result.

The duties and relation of the medical profession and medical schools to the public are changing rapidly. The recent epidemic of influenza and shortly before that the raising of armies for the great war, have emphasized the necessity for proper health measures, whether they be preventive or curative. This has been publicly realized by such statesmen as Lloyd George and by the sponsors for the health of our army. The demand of the public has been increasing; and at present, twenty-eight states and two cities conduct medical schools as a part of their system of higher education. In order to accomplish results it is necessary for the state to use various agencies; so that when the University founded the medical school primarily with an idea of educating physicians, the development that would shortly be necessary was hardly realized.

In the development of these medical schools in the various states, the results along other lines have been almost as important as the educational side. In the University of Kansas this has taken several directions. The greatest development has been in the hospital—primarily for presenting illustrative cases to students; but at the same time, taking care of crippled children and other cases that under the old order might be neglected.

In order to provide a working library, gifts and purchases of periodicals and books have constantly been made. These books are now beginning to be varied and plentiful enough to make a working library of considerable efficiency.

It has been necessary also to develop laboratories not only for the care of patients in the hospital and the instruction of students; but these have grown so greatly that they also are being used as a public health measure; particularly in regard to venereal diseases.

Also, in order to properly conduct a hospital, it has been necessary to conduct a training school for nurses. Since the demand for public health nursing has become so great, the next expansion will probably occur in this direction. A lack of funds has prevented the development before this time.

This shows definitely that the medical work of a state university has long since outgrown the restricted purpose of merely educating physicians and occupied a broad position in relation to the medical activities of that state; and that it can take its proper place in relation to the profession and the public only by the interest and help of the profession and the appropriation of sufficient funds by the state legislature to achieve these results. Kansas has lagged behind the more progressive states in this particular. May we not hope that this will soon be remedied and that it will occupy its rightful position of maximum usefulness in the near future?

Medical Education and the Period of Reconstruction.

C. F. Nelson, M.D., Ph.D.

University of Kansas, Lawrence.

The world is at the present moment emerging from the horrors of a gigantic conflict which has been destructive beyond our utmost powers of comprehension. Hundreds of thousands of men, women and children are today wounded, sick, undernourished and wrecked nervously as a direct result of this struggle. The war has been won fundamentally, probably wholly, because of the possibility of unselfish cooperative effort on the part of a score of nations and by a spirit of purpose and single-mindedness on the part of millions of loyal men and women who have given liberally both of their substance and of life itself. The fighting is over for the moment and will, in all probability, not be renewed. But real peace can come only with the happiness which abundant health can bring. And now the period of reconstruction is before us.

The State of Kansas has at this moment a distinct and imperative duty to perform

in educating its share of young physicians to help bring comfort and happiness to the many sufferers in Europe as well as to its own boys at home and abroad. Co-operation has won the war and co-operative effort will make the period of reconstruction happy and genuinely possible.

Our efforts should, however, be commensurate with our needs. A distinct departure in the policy of expenditure for medical education is needed in Kansas at once. Preparations for peace must be as simple as were the preparations for war. In providing funds for educating medical men, who are now so sorely needed both at home and abroad, the increased cost in maintaining a first class medical school must be taken into account or nothing worth while can really be accomplished. With five counties in the state now without one bit of medical aid, Kansas must be generous; with devastated Europe needing medical assistance and calling for men her duty in this regard cannot but be clear.

There can be no possible mistake in inaugurating a liberal policy toward educating men for the profession of medicine. Our country needs highly trained medical men more than ever. The conservation of life and happiness for which this war was fought must be put largely into their hands. If men, capable and well enough informed for this task, are not regularly forthcoming, freedom, liberty and peace lost a great deal of their meaning.

Our Government has inaugurated a splendid and significant movement in its comprehensive program for the rehabilitation of disabled soldiers. This impetus to conserve health surely contains the very essence of peace and the antithesis of war. It must spread and it will do so irresistably until each individual citizen comes under its benign influence. Many of the leaders and workers in such a movement must necessarily be high minded, well trained medical men. Kansas cannot afford to be unprepared or not to furnish her share. She can easily afford to support a really first class medical school.

The Dispensary.

NELSE F. OCKERBLAD, B.S., M.D.,
Chief of Clinic.

The Dispensary Clinic of the Medical School of the University of Kansas is primarily used for "case teaching" supplementary to the purely didactic classroom instruction and is thus an indispensable part of the scheme for the training of medical students. Secondarily, the Dispensary Clinic serves as a social service unit in the treatment of disease and in the betterment physically of those who look to us for relief from suffering. In order to be most effective both in teaching and in social uplift through the cure or relief of disease we must have a certain number of free beds in the hospital. As conditions are now we can only admit such patients to the hospital as can pay ten dollars a week, and it almost invariably happens that the most interesting and valuable cases from a teaching point of view and the most needy from an economic standpoint are without means, and are forced to seek relief elsewhere or silently suffer in their homes without proper medical attention.

If we had available 200 free beds in our hospital the attendance at the dispensary clinic would at once increase greatly. Many persons would thus be cured of their disease or be so improved that they could be returned as useful members of society, able to earn their own living again, who might, on the other hand, without such scientific intelligent treatment, become a burden to the state either directly or indirectly.

Another function of our free dispensary is the scientific and exhaustive study of disease, and to this end we should have available every device, instrument or method known to the profession. The Medical School through its clinic would thus properly become a "source of light" to the profession of this section of the country.

A dispensary clinic today is not complete without a social service department where proper following of cases may take place

to discover whether the persons are in need of free treatment and then to see that such persons take the prescribed treatment. The social and financial status of each patient should be investigated completely so that patients who are well able to pay for treatment are directed to a qualified physician and are not made wards of the state.

We have then four aims:

(1) To instruct medical students.

(2) To benefit the social order by proper medical attention to disease.

(3) To study disease exhaustively.

(4) To be a "source of light" to the profession.

And three crying needs:

(1) A complete supply of instruments and equipment.

(2) Free beds available in our hospital.

(3) A social service department.

We have the personnel to do this work. We have abundant human material at hand for teaching and research purposes, all we need is "tools" to work with, that this institution in all its aspects may become second to none among the medical schools of America.

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The Venereal Clinic.

NELSE F. OCKERBLAD, B.S., M.D.

The venereal or urological clinic was opened May 15, 1918, as an effort to give proper time and attention to the diagnosis and treatment of venereal diseases. A short time after the clinic was established it was designated as one of the venereal clinics for the health area of Kansas City by the United States Public Health Service through the Kansas State Board of Health.

As a matter of record and also to be scientifically correct we plan to confirm every diagnosis of syphilis with the laboratory tests. In primary syphilis we rely on the demonstration of the spirocheta pallida of Shaudin with the dark field stage for our diagnosis. When the spirocheta is found, no further tests are necessary and treatment is at once begun. We strive to intelligently separate chancroids from true chancres and accord to each its proper treatment.

Since we have attached to our department of pathology the very excellent Wassermann laboratory conducted by the State Board of Health for the United States Public Health Service with Dr. Baker in charge we have a ready and reliable means of establishing the diagnosis of syphilis in doubtful cases. As a matter of confirmation both to the serologist and the clinician the blood of all clinically syphilitic patients is tested and findings recorded on the patient's dispensary chart. We are thus able to have on our dispensary records either a positive spirochete search or a positive Wassermann before beginning antisyphilitic treatment.

Beginning November 1, 1918, we have had available for free treatment a supply of arsphenamine assigned to us by the United States Public Health Service through the Kansas State Board of Health. With this supply at hand we are able to give immediate attention to many desperately infectious cases of syphilis, that come to our attention.

We are proceeding to treat active syphilis on the basis laid down by the United States Army Medical Corps, which is briefly this:

Treatment to cover a period of two years during which time Salvarsan (arsphenamine) is given intravenously in courses of six, one week apart, four courses in each year. During each course of arsphenamine mercury is given by injection, nine to ten injections of the insoluble and twenty-five to thirty of the soluble mercury salts. Potassium or sodium iodide is given only when there are lesions to be absorbed.

The gonorrhea cases are treated in the manner approved by the most advanced urologists of our times. Endeavor is made to establish the presence of the gonococcus before beginning treatment, isolating it either from urethral pus or secretions expressed from the seminal vesicles or prostate or from the centrifuged morning urine. Male patients are immediately put

on a routine treatment as soon as the diagnosis is established.

It is difficult to get female gonorrhea patients to continue treatment after the acute symptoms have subsided. We try to impress every patient with the seriousness of his disease not alone to himself but to all those with whom he is immediately or remotely associated.

The problem of familial syphilis has as yet only been touched upon, and by familial syphilis I mean syphilis contracted by the father and given to the wife or mother, or where father, mother and children all have syphilis. We have a large number of such families under our observation now and are finding an ever increasing number of them. To properly study this important problem we need the services of a visiting nurse or social worker with a nurse's training who will be able to coordinate the work of the doctor by acting between the doctor and the patients to see to it that the effort of the dispensary doctor is not wasted because of neglect of treatment or instructions improperly carried out.

In spite of our best efforts we believe that venereal disease is on the increase—at least it is among the civilian population—and in order to properly combat this tendency we must adopt a plan of procedure which should include all of the following very definite activities:

(1) Study the source of infection and eradicate them with the help of the State Board of Health.

(2) Treat the infected persons so as to render them non-infectious.

(3) By a campaign of education seek to establish a wholesome fear coupled with a correct knowledge of venereal infections.

(4) Enforce the laws now on the statute books.

(5) Teach medical students and the medical profession generally that venereal diseases are worthy of our very best efforts and thought and that such patients are not to be treated as outcasts if they cannot pay or "bled to death" if they can pay.

If we can carry out the above program we can feel sure that we are doing our level best to eradicate venereal disease and maintain the high ideals of a state institution.

The Medical School and the Great War.

ELEANOR MAUDE KIBBEY, A.B.

Secretary-Registrar The School of Medicine, University of Kansas.

The great war has fully demonstrated the value of technical training; not only in the making of dreadnaughts and the perfecting of aeroplanes, but in the less spectacular science of medicine. Its importance was fully recognized by the government in its request that the medical schools continue in operation, stating that they were munition factories and that the students must not be permitted to enlist. They also requested that enough men must be retained on the faculties to make it possible for the schools to continue their work of putting men into the profession to care for the soldiers abroad and at home and to care for the health of those who were behind the army.

The faculty of the School of Medicine of the University of Kansas has responded so freely to the call of the War Department that a gigantic burden has been borne by those remaining. The school has worked under the greatest difficulties of its varied existence, each man doing more than double duty under inglorious circumstances. Even as "clothes do not make the man," the uniform does not make the hero; and much heroic work has been done by the physician in civilian's clothes. The raging of the influenza epidemic emphasized this fact most forcibly; and the wisdom of the government in providing for medical education throughout the war was more than justified. The work of physicians and of nurses and of students of medicine was worthy of their noble calling.

The School of Medicine of the University of Kansas has a high pride in the actual war service rendered by its various war departments. They have all given their services most generously; and in several

cases their lives have been the price. The lists of those in the service—its faculty, some of its former students, its alumni, its alumni by affiliation*, the alumnæ of the Training School for Nurses—though not entirely complete, show the breadth of the scope of the work of the School of Medicine. Those identified with it are justly proud of this record of service for humanity.

It has been the sacred privilege and the mournful glory of the School of Medicine to contribute five gold stars to the service flag of the institution. The first among those brave ones who so simply gave all was Captain William Thomas Fitzsimmons ('12,—the first American officer to die on foreign soil); closely followed by Lieutenant Benjamin W. J. Worrall ('06), and then Lieutenant Carl Culver ('11). In addition to these, the epidemic of influenza took toll from those self-sacrificing ones; and Dr. Claude H. Case ('07) died in the service of his country while administering to the stricken.

To one not in the profession, it was a splendid tribute to the unostentatious bravery of mankind to see the quiet matter-of-course manner in which the nurses and students of medicine responded to the call to care for their suffering comrades in the Students' Army Training Corps of the University. Brought face to face with the many tragedies of the scourge, they did not shirk or shrink; but valiantly volunteered their services and accomplished unbelievable stupendous work for long hours, one or another dropping out, incapacitated by the disease for a time, but returning and courageously continuing the struggle. The result of this strenuous and self-sacrificing effort was that the mortality of the influenza epidemic of the Students' Army Training Corps of the University of Kansas was far lower than that of any other institution recorded — there being only thirty-four deaths out of the nine hundred students affected.

In this disinterested heroism, however, one of the senior medical students, Russell Calvin Hepler ('19), a member of the Medical Enlisted Reserve Corps, whose attitude had been one of the finest courage and whose zeal had been untiring, succumbed to the disease. A complication of meningitis followed, and his tragic death is a memento of the service of the men of the Medical School to their fellow-men and their country.

"He did not die where bursting shell
Shudder and rend the shaking air,
Nor in some small French village where
The Priest, a faithful sentinel,
In his ruined cloisters tolls his bell;
But here in unsung, patient care,
He bent in mercy's deed to share,
And in unselfish duty fell."

—(Private Willard Wattles,
Camp Funston.)

In the act of the legislature establishing the University in 1862 the founding of a Medical School was contemplated, but conditions were such that it was impossible to carry out these plans at this time. Some steps were taken, as opportunity offered, to further the formation of a Medical School, and in 1880 the "Preparatory Medical Course," under the administration of the College, was established. This continued until 1899, when the School of Medicine was definitely organized, and the first two years of medical instruction was offered.

In the fall of 1905, the Kansas City Medical College (founded in 1869), the Medicochirurgical College (founded in 1896), and the College of Physicians and Surgeons (founded in 1893), were merged into the last two years of a four-year medical course under direction of the University of Kansas.

Excerpts by The Prodigal.

An excellent treatment for scalds and burns is a poultice of bicarbonate of soda. It relieves the pain and is aseptic. It should be left on until the wound is healed, unless there is a rise in temperature or an offensive odor developed.

Books and periodicals which have a glazed finished paper for a background are hard on the eyes of the reader. A dead white or neutral tinted paper is restful to the eyes.

While reading, always sit so that the light falls on the print from the left side and from behind. In the English language, which most of us use, we read from left to right. It is less tiresome for the iris to contract suddenly in facing the light and gradually relax in backing away than to gradually contract up to the point

of facing the light or against it and then to relax.

Close application of the eyes in reading should not be continued longer than from twenty to thirty minutes without an intermission of from three to five minutes.

When the hearing becomes dull or slightly impaired, it may be restored or kept from getting worse by pressing the tragus of the affected ear firmly against the external auditory canal with the finger and jiggle back and forth a dozen times or more. The column of air when pressure is made will push the drumhead in and relax when released and massage the drumhead and the joints of the bones in the middle ear and render the joints more supple. This massage should not be done more frequently than once or twice a week, according to the necessity of the case or the effect produced. Resort should be had to this measure and to inflation of the Eustachian tubes and middle ear according to the benefit received. Overtreatment by massage as heretofore recommended, or inflation, will do injury. In the case of beginning impaired hearing, inflation of the Eustachian tubes and middle ear is usually necessary. If a Politzer bag is not in evidence, Valsalva's method of inflation may be used. Valsalva's method consists in taking a full breath, then shut the mouth and hold the nose tightly so no air escapes from either, then try to force the air out through the nose. When the air passes up through the tubes there is a sense of fullness felt in the middle ear and a crackling sound. If but one ear is involved the normal ear should be protected by pressing the tragus of that ear firmly against its auditory canal while inflating the other ear. By so doing a solid column of air is held against the drumhead of the normal ear and protects it.

In a majority of cases dullness of hearing is caused by catarrh in the middle ear. This catarrh is from continuity of tissue. That is to say the pathological trouble has traveled from the posterior naso-pharynx in the mucous membrane of the Eustachian tube into the middle ear. Hence it is better to treat the naso-pharyngeal mucous membrane in addition to the massage of the middle ear. The sooner treatment is begun after this dullness of hearing is recognized, the better. Overtreatment is the great danger in these cases. The Schneiderian and mucous membrane of the nose and pharynx should not be treated, in these cases, to the extent of irritation. After the treatment the patient should have a feeling of relief and comfort; should hear better, and the head should feel clear.

If an unpleasant stuffy feeling is present and the hearing is not improved at the time, quit or change the treatment. Cerumen in excess together with excessive itching in the auditory canal, one or both is a warning to the owner that trouble has begun and, like the beginning of a fire, the time to put it out of business is now. And now is the time for treatment with almost a positive assurance of success. The cerumenous glands and the mucous membrane (or glands) are irritated, causing over-stimulation, but their function has not been destroyed and they can be restored to normal with mild treatment. But if this irritation is continued the over-stimulation in the course of time will destroy the function of the glands and membrane and when once destroyed they cannot be recreated. A permanent pathological condition is the result of the sin of omission.

It should be remembered that over-medication is fatal and that under-medication gives the patient a chance for his life.

When in doubt the patient should have the benefit of the doubt, and—don't.

It is like the late Frederick Douglass said when asked "What shall we do with the negro?" He replied, "Let him alone and give him a chance, but let him alone."

When a whole catalogue of drugs are recommended for a certain disease it is

proof that the remedy for the disease is not known. The treatment is fashioned after the shotgun prescriptions of the near ancients.

The cause of multiple sclerosis is said to be unknown. Hence its early recognition is important that the treatment may be *palliative* and *expectant.*

It is said that diuretics are indicated in cardiac edema but not in nephritic edema. Sudorifics are indicated in nephritic edema.

The body temperature of a febrile person is reduced more easily by an antipyretic than is the body temperature of a normal person.

That the rise of arterial pressure caused by a dose of strychnine is due to its toxic effect. A safe dose of strychnine does not raise the arterial pressure materially, either in man or beast.

Lassitude, headache and malaise experienced in a close atmosphere in a crowded hall are due to heat and humidity rather than to the inspiration of waste products. The effect of heat and moisture on the skin is the determining cause of the discomfort.

Do You Blame Him?

Dr. M—— was called to see a lawyer. When the doctor entered the room the lawyer said, "Doctor, I have been suffering the pangs of hell for the last two hours."

"What!" said the doctor. "So soon?" And now he is mad at M——.

For Better Rural Health.

Much remains to be done in rural districts, according to the annual report of the Secretary of Agriculture, to control such pests as mosquitoes and the hookworm, to eliminate the sources of typhoid fever, and, even more, to give the country districts the advantage of modern hospitals, nursing and specialized medical practice.

Noting that many agencies, some of them private enterprises with large funds, are working for improvement, the report says that the Department of Agriculture, through its home demonstration service, is giving valuable aid, and the public health service is increasingly extending its functions.

To what extent the further projection of effort is a matter for state or local action remains to be determined, says the Secretary, but it seems clear that there should be no cessation of activities until there has been completed in every rural community of the Union an effective sanitary service and, through the provision of adequate machinery, steps taken to control and eliminate the sources of disease and to provide the necessary modern medical and dental facilities, easily accessible to the mass of the people.

A Short-sighted Druggist.

A correspondent writes: "I went to a near-by drug store and asked for twenty-five cents' worth of Liquor Antisepticus Alkalinus. I got one ounce! The druggist charged me fifteen cents an ounce, and ten cents for the container. Next time I fear I shall be forced to get Glycothymoline." To penalize a man who calls for an official product so as to drive him to ask for a "patent medicine" of the same general character is both poor pharmacy and bad business. (Jour. A. M. A., November 23, 1918, p. 1745.)

Digestive Absurdities.

Scientific investigations have demonstrated beyond any doubt the irrationality of the combinations of digestive ferments which go to make up the various brands of aromatic digestive tablets, and all chemists and manufacturing pharmacists are familiar with these facts. The excuse for manufacturing them is that there is a call for them. It is a question whether the physician who ignorantly prescribes aromatic digestive tablets is not more morally culpable than the pharmaceutical house that supplies what such physicians demand. (Jour. A. M. A., November 2, 1918, p. 1489.)

The Call of Humanity
is "Join the Red Cross"

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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How Can the Medical School Be of More Service to the Profession?

There was a time when all that was expected of a medical school was to prepare men for the practice of medicine. We expect more of it now. We not only expect it to prepare men for practice, and that is a vastly greater task than it was twenty-five years ago, but we expect the medical school to keep them in a state of preparation—or at least to supply the means for doing so.

In connection with most all of the larger medical schools are clinics and post graduate courses that are open to practitioners; and on account of the fact that they are conducted by experienced clinicians and teachers they offer particular advantages for practical instruction.

The faculty of the modern medical school is made up largely of men who are especially trained and adapted to teaching and who devote their whole time to the school work. Such full time men, if they are efficient, are students as well as teachers. To be good teachers they must also be good students, and it is to such men as these that we look for many of the newer developments. They have the time, the inclination and the stimulus to carry out the long and tedious researches which are proving and disproving many of the old theories of medicine.

Large clinics must be available for instruction in the various departments of medical and surgical practice, and the men who serve in these departments have wonderful opportunities for careful observation and classification. From these men we derive much of our knowledge of diagnosis and of therapeutics.

The medical school is not less important as a preparatory school for physicians, but it has become of much greater importance in its relation to the practice of medicine. Just at this time it may be well to consider in what way our own medical school may be made more serviceable to the physicians of Kansas, for we take it that all our state institutions are intended to serve, to as large extent as possible, the various interests of the people. A considerable advance was made in this direction when the hospital was opened to the poor unfortunates of the state, but there are great facilities there that might be used for the benefit of the physicians of Kansas, and through them for the benefit of the people.

For several years a school for health officers has been conducted at Lawrence and Rosedale. While this has no doubt been highly appreciated, it is too narrow in its scope. Any course of three or four weeks, once a year, is entirely inadequate for the needs of the profession. It might be possible without any serious disarrangement of the regular curriculum of the school to give a series of courses or a continuous course, of clinical and post-graduate instruction. A good many of our men now avail themselves of the clinical advantages offered by Chicago, St. Louis, and other cities, but there are a thousand men in the state who do not. Many because they cannot afford it, others because they cannot leave their business for a sufficient time. The clinical instruction that can be had at the Rosedale School would be very attractive to many of these, and especially so if they could select their least busy time for going.

There is plenty of clinical material to be had and there are excellent instructors. Why should they not be utilized by the physicians of Kansas to the benefit of the people of Kansas?

There is yet another way in which the medical school may be of more service to the physicians of Kansas, and at the same time provide a favorable influence in its own progress. A physician here may be immensely learned in some branch of medicine, his opinion may be respected in Chicago, his papers may be carefully read in New York, but unless the people at home know him and know his ability, he will probably starve to death.

When the state employs teachers for the medical school it does not thereby purchase all the products of their brains, but it is fair to presume that they are loyal to the institution they serve and are interested in its progress. We can not blame the members of the faculty if they wish their work to be known by the men in other schools. We cannot blame them if their first desire is that the school with which they are connected should stand well in the estimation of other schools. But if all the reports of the work done by the members of the faculty and all the papers written by them were published in the Journal, the profession of Kansas would more fully appreciate the importance of the school. Through the profession the people would become familiar with its work and a more generous support would be given it.

It is unfortunate but true that the medical profession of Kansas does not sufficiently appreciate the excellence of its school of medicine. Only those who are its graduates or who are in close touch with its faculty really know much about it. The others only realize the high standing and special qualifications of these men when some other school has taken them away. We believe the profession of Kansas would be fully as appreciative of the merits of these men as the officers of other schools if given the opportunity to read their papers and hear them talk. We believe the publication of articles by these men in the Journal would help to give them standing at home. We also believe that if arrangements could be made for a series of district meetings and members of the faculty engaged to lecture on various subjects, the profession would not only be benefited, but would more fully recognize the possibilities of the school, and its members would use their influence and support for its upbuilding.

———R———

Government Control in Medicine.

It is hardly to be expected that after the great disarrangement of all our private and public affairs they will very readily, or ever, resume their ante-bellum status.

Not reluctantly, but gradually and persistently the states have surrendered their long cherished prerogatives to federal administration. With the growth in magnitude of our industries some centralized authority has become an economic necessity. Before the war sentiment in favor of the government control of public utilities seemed to be growing. What effect the government's emergency administration of these utilities will have upon the ultimate solution of these problems is yet to be learned. The people are still under the restraint occasioned by the war, and it is impossible to determine what impression of a future federal administration of these utilities they may have received.

The emergency which required the placing of a large proportion of the most active men in our profession under federal control may have a very important effect upon the future of medicine. In some of the publicity matter recently sent out for the press it is suggested by a member of the Board of Health of North Carolina "that American soldiers having been carefully treated, having been subjected to scientific methods of diagnosis, blood counts, feces and urine analysis, X-rays, etc., etc., after the war, in all probability will refuse to submit to a medical service that is inferior to what the army has given them." And, "that the question of health matters being taken over as a whole

by the state and federal governments, and the practice of medicine even subsidized, may be one of the results that will eventuate."

Any estimate made at this time, by any officer or civilian, as to the sentiment of the soldiers as a whole upon public health administration or the future of medicine, must be premature. When these soldiers are at liberty to speak without restraint we may learn if the larger number approve and appreciate the excellent work of the medical department, or resent the necessary restrictions to their personal liberties.

No one is yet prepared to say if our civilian population has been more strongly impressed by the carefully systematized and thoroughly efficient service of the medical department under the normal health conditions of our cantonments, or by the ouerstrained service and overtaxed facilities of this department during such crises as were occasioned by the epidemic of measles and pneumonia last winter and the recent epidemic of influenza.

Nor can we predict the attitude of the various medical officers now in service toward the question of federal control of our public health regulations and its possible regulation of the practice of medicine, until these men have been released from the service and are free to express themselves.

The medical department of the army has accomplished a herculean task and has done so with great credit to the medical profession, but we believe, and the reports of last winter justify the belief, that had it been given a free hand, been relieved of a great deal of government red tape, been relieved of the interference of superior officers of other departments, the medical department would have been more quickly and more efficiently organized and would have been more flexible and easily adapted to the emergency requirements that were to be anticipated.

No one is prepared to say with conviction that a medical organization independent of government regulations, organized and equipped for the purpose by the great physicians and surgeons in this country, would have been less efficient. Mr. Hughes has recently said in regard to government control of public utilities:

"It is regrettable, but it is true, that governmental enterprise tends constantly to inefficiency. . . . It cannot fail to be observed that even in connection with the war, despite the endeavor and patriotic impulse of countless workers, inefficiency in important fields of activity has been notorious. The notion that the conduct of business by government tends to be efficient is a superstition cherished by those who either know nothing of government or who know nothing of business. The tendency is strongly the other way.

"Along with this is the grave question of putting the direct operation of these great activities unnecessarily under political control. That is the most serious question. The dovetailing of government with business is apt to injure both."

We do not doubt that the federal administration of our public health regulation would be efficient, but only through municipal and state administration of such regulations can such flexibility and discrimination in their enforcement be secured as to safeguard our industrial pursuits without endangering the public health.

———R———

There are 290 medical students from Kansas in the various schools of the country. Of these 241 are in class "A" schools and 49 in class "C" schools. Of this number 137, or a little more than 47 per cent, are in the Kansas University Medical Department.

———R———

Don't worry. When everybody has been tonsillectomized there will still be the spleen, which seems not to have any useful function.

———R———

We don't envy the health officers. To enforce the ordinary health regulation is sometimes rather difficult, but to devise and try to enforce new regulations to control the epidemic of influenza is some job.

The Red Cross in Jerusalem

How American Red Cross physicians engaged in relief work in Jerusalem are accomplishing worth while results in the face of great difficulties, and what they are up against, is shown in a report just received from W. S. Dodd, A.R.C. doctor working in that section.

With two capable English trained nurses and three native helpers, more or less useful, Dr. Dodd, his "hospital" housed under tents, performed 252 operations in seven weeks, besides giving medical examinations, treatment and counsel to hundreds of the destitute inhabitants and refugees.

His report says in part: "The work of the hospital was of the plainest sort—it might be called primitive. About twenty-five tents comprised the hospital proper, with a dispensary tent, and tents for the living quarters of the staff.

"The soil was all the purest sea-sand with thistles and scant grass; going barefoot was the universal custom, and in our own quarters we of the staff used to follow that custom with great pleasure. * * *

"The professional side of the work was of the greatest interest to me and every day was a pleasure. The clinics numbered sixty to a hundred a day. Of course we had all classes of cases in medicine and general surgery, but by far the larger proportion of our patients were eye cases.

"Of the 252 operation that I did in less than seven weeks, 222 were for the eyes. This is the number of persons operated on, most of them having more than one operation, perhaps on all four lids, so that I really operated on 408 eyes.

"There were some cataracts, not more than would be seen in the same number of cases elsewhere, but trachoma and its consequences accounts for almost all of the eye troubles in this land. I set out to treat these cases radically and secured fine results when I could keep the patients long enough for a reasonable after-treatment. But even so, the number of eyes that can be saved from partial and total blindness is large and the economic value of each eye thus saved is enough to make the prosecution of this line of work of the greatest importance for the redemption of the land.

"The accident cases are always interesting. I had the last end of treatment of some cases of bombed hands, of which there had been quite a number in the earlier days. These were largely in children, and were due to their picking up unexploded Turkish bombs that were lying in the fields from the time of the British advance in the Gaza region. Many fingers and even hands were lost from this cause.

"Vermin was the great enemy we had to fight. Fleas were hardly counted as a problem because we could do nothing against them, they were everywhere and inevitable, and so far as we know at present, not being the carriers of any special diseases, did not come within the hostility of a medical conscience.

"Lice and maggots were a daily terror. How many wounds and injuries came to us filled with maggots I cannot tell. A favorite dressing for a wound is a piece of raw meat, a breeding-place for maggots, and they can hardly be blamed for invading the adjoining premises.

"Many a child had to be put under chloroform in order to search out and pull from their hiding places deep in the middle ear a half dozen wriggling maggots whose every motion was causing torture to the innocent victim.

"A woman came to the clinic complaining of headache. A single sore on her face led to questioning, and when she rather unwillingly undid her turban we found an exaggerated case of impetigo, and every separate sore was as if the whole thickness of the scalp down to the bone had been punched out, and every sore was a nest of maggots. I removed sixty at the first seance, and at the first dressing next day the nurse had more to do. The headache was cured without further treatment. And these are not the most loathsome cases that we saw.

"Another great difficulty with which we had to contend was the filthy habits of the people. In spite of providing proper sanitary facilities, we were compelled to have a scavenger go around every morning and clean up the filth from around the tents of the patients. The women were as bad offenders as the men. We made it a rule that anyone known to have violated these simple sanitary regulations must go without their dinner next day, and this was quite effective punishment."

Typically American.

Every doctor in the United States should be interested in encouraging American manufacture of typically American medical products. Let us, by enthusiastic patronage of all-American manufacturers, so firmly establish the American supremacy in this field that there will never be

the slightest danger of its passing back to Germany.

One typically American invention is the new wax-impregnated open-mesh lace dressing for wounds, burns, bruises, etc., which bids fair to revolutionize the present-day dressing methods.

Careful tests in large industrial hospitals show that by using this lace mesh, 50 to 75 per cent of the gauze, absorbent cotton, and roller bandages, may be saved, as well as hours of time of surgeons and nurses, not to mention the saving of agony to the patient experienced in the removal of the old sticking secretion-stiffened pad of dressings, for this remarkable dressing does not stick.

Just by way of introduction, the Abbott Laboratories, Chicago, Ill., who make this parresined lace-mesh surgical dressing, offer a special outfit containing a box of six envelopes of the lace-mesh, an ounce of Dakin's Dichloramine-T, and four ounces of Chlorcosane—the solvent for Dichloramine-T—prepaid to any point of the United States for only $2.50. They include, without charge, in the shipment, a trial bottle of Chlorazene, Dakin's water-soluble, stable antiseptic, and one of Digipoten, a typically American digitalis preparation, which leaves you no excuse for using the German. Send for a package today. It has the Abbott guarantee of purity and accuracy.

Ravages of the Influenza Epidemic.

The influenza epidemic has thus far taken a much heavier toll of American life than has the great war. The total loss of life throughout the country is not known, but the Bureau of the Census has been publishing, for forty-six large cities having a combined population estimated at 23,000,000, weekly reports showing the mortality from influenza and pneumonia. These reports, which cover the period from September 8 to November 9, inclusive, show a total of 82,306 deaths from these causes. It is estimated that during a similar period of time the normal number of deaths due to influenza and pneumonia in the same cities would be about 4,000, leaving approximately 78,000 as the number properly chargeable to the epidemic.

The total casualties in the American Expeditionary Forces have recently been unofficially estimated at 100,000. On the basis of the number thus far reported. it may be assumed that the deaths from all causes, including disease and accidents, are probably less than 45 per cent and may not be more than 40 per cent of the total casualties. On this assumption the loss of life in the American Expeditionary Forces to date is about 40,000 or 45,000.

Thus, in forty-six American cities having a combined population of only a little more than one-fifth the total for the country, the mortality resulting from the influenza epidemic during the nine weeks' period ended November 9 was nearly double that in the American Expeditionary Forces from the time the first contingent landed in France until the cessation of hostilities.

For the forty-six cities taken as a group, the epidemic reached its height during the two weeks ended October 26, for which period 40,782 deaths were reported—19,938 for the week ended October 19 and 20,844 for the following week. Since October 26, however, the decline has been pronounced. During the week ended November 2, 14,857 deaths occurred, and during the following week only 7,798. The only city in which the number of deaths reported for the week ended November 9 exceeded the number occurring during the previous week was Spokane, Washington.

In general, the epidemic traversed the country from east to west. In a number of eastern cities—notably Boston, where the greatest mortality occurred during the week ended October 5—the largest numbers of deaths were reported for earlier periods than that which covered the height of the epidemic for the forty-six cities taken as a group. On the other hand, in New Haven, New York, Pittsburgh, and Rochester, the maximum mortality occurred somewhat later than in eastern cities generally. In Baltimore, Buffalo, and Philadelphia, the two weeks' period ended October 26 showed the greatest number of deaths. For the entire nine weeks' period the greatest mortality due to the epidemic, in proportion to population—7.4 per thousand—occurred in Philadelphia; and the next greatest, 6.7 per thousand—was reported for Baltimore.

The Prophylactic Value of Vaccine in Influenza.

Some of the reports on the value of vaccines in preventing influenza do not appear to be very encouraging. In the Journal of the American Medical Association, December 7, will be found a report by Dr. Barnes

on his experience with Leary's vaccine. We are unable to find anything in his report that could be considered as indicating any particular immunizing value in this serum.

In the literature sent out by Sherman, however, some very positive and striking results are reported. In the Philadelphia Electric Company thirty-five hundred employes were inoculated and of these not one had influenza. The Sherman vaccine has been used by several practitioners in their private practice. From some of these we learn that only a small per cent of those vaccinated have had influenza, and in those cases that did occur the symptoms were very mild. Those who have made therapeutic use of the Sherman vaccine also report good results.

The Medical Profession After the War.

In April, 1917, our country called on the medical profession for volunteers for medical service. The response was both prompt and generous. Again and again the call came, and each time met similar prompt and generous response. Some 35,000 physicians have responded to these calls and are serving in the army or in the navy. In addition, about 25,000 physicians have given freely of their time and labor to work on Selective Service Boards, thus making possible that efficient, physically fit machine—the National Army.

It is too soon—the world, victorious and vanquished, too unsettled—to say what is coming and what is to be done. It is an hour in which nations are being made, unmade and remade. We hear, we talk, we read of reconstruction. The reconstruction problems are, in the main, twofold: one, the salvaging of mutilated humanity; the other, the reconstruction of devastated cities, towns and villages. The former, the salvaging of the heroic remnants of war-worn men, is the more important. Our reconstruction problem as applied to the physical reconstruction of the disabled soldiers is certain not to be the gigantic task that it would have been had the war continued for a long period of time. There will, of course, be much to do in this regard; but this work is in competent hands and well provided for. Our reconstruction problem as it applies to the returning of more than 30,000 military physicians to civilian life is again not a problem of magnitude. The physician before he went to war was, in most instances, a man of home and family, and in most instances home, family, his professional confreres and the community wait to welcome him with honors.

However, our reconstruction problem as it concerns the relation of the physician to the great social problems that are to arise "after the war," is a problem of magnitude. One's senses are startled by phrases in the modern writings on social and economic subjects. One hears of "equalization of risk and return," of "conscription of wealth," of "health insurance," of "national ownership," of "state medicine," of a "league of nations," "international medical alliances," and similar conceptions. With these, and as a part of these, will be new problems of the relation of physicians to each other and to the public. Physicians will have as much influence as any other class in the weaving of the new social fabric. It is well to realize this and to appreciate the need of closer knitting together of the profession itself—of stronger organization—so that we may face these problems with the strength of many minds united. Thus the medical profession may be able, not only to secure the rights and recognition it merits, but also to have that real influence necessary for the best interests of the public health in the new order of things. The medical profession has served, it serves and it will continue to serve when called on, but in its altruism must not forget that the profession will have to guard its own rights and prerogatives if they are to be guarded at all.—Journal A.M.A., November 16, 1918.

Value of Vaccination Against Influenza.

There is no conclusive evidence that the Pfeiffer bacillus plays any greater role, if as great, in the present epidemic than any other bacteria found in the respiratory tract in this disease. Also, the influenza bacillus is a very poor antigen. There is, in fact, nothing to show that definite antibodies against this bacillus develop in the course of influenza. Animal experiments show that it requires prolonged immunization before any response becomes apparent. Again, there is no record of controlled experiments on human beings with influenza vaccine. From this it is evident that vaccination against influenza is in a wholly experimental stage. (Jour. A. M. A., November 9, 1918, p. 1583.)

Elixir of Enzymes

is a palatable aid to digestion; an agreeable vehicle for iodids, bromids, salicylates, etc., and supplies the curdling ferment for making junket.

Pituitary Liquid (Armour)
(Liq. Hypophysis)

is physiologically standardized and is entirely free from chemical preservatives. ½cc and 1cc ampoules, 6 in box.

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Extract of Red Bone Marrow

is a great reconstructive and will be found of value to patients convalescing from Influenza and other troubles.

Armour's Surgical Catgut Ligatures

are the finest thing of the kind on the market; they are strong, smooth and sterile. Plain and 10, 20, 30 and 40 day Chromic, sizes Nos. 000 to 4, inclusive. At present, 60 inch lengths only.

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KANSAS CITY, KANSAS

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Very truly yours,
S. S. GLASSCOCK, M.D., Res. Supt.
A. L. LUDWICK, A.M., M.D., Asst. Supt.
EDITH GLASSCOCK, B.S.
Business Manager

Office 910 Rialto Bldg., Kansas City, Mo.

A Commendable Move.

The profession will no doubt be interested in the recent announcement of the Owl Drug Co. stating that beginning December 1 no preparations for the self-treatment of venereal diseases will be sold in the twenty-nine retail stores of the company, located on the Pacific Coast and in the Middle West. When such preparations are called for, the salesman is instructed to explain the new policy of the company and give the customer a carefully prepared confidential circular, which explains the seriousness of all venereal diseases and the importance of consulting a reliable physician and a list of such will be furnished upon request.

℞

New and Nonofficial Remedies.

Lutein Tablets, H. W. and D, 2 Grains. —Each tablet contains 2 grains of lutein (the fully developed corpora lutea of the hog, dried and powdered). Hynson, Westcott & Dunning, Baltimore, Md. (Journal A. M. A., Nov. 2, 1918, p. 1485.)

Rabies Vaccine (Harris). — An antirabic vaccine standardized by the method of Dr. Harris and stored in vacuo. Each package contains vaccine and apparatus for the administration of one complete treatment. One dose is given daily for ten days or more. National Pathological Laboratories, Chicago. (Jour. A. M. A., November 30, 1918, p. 1825.)

℞

War Surgery.

J. J. Moorhead (New York), France (Journal A. M. A., August 31, 1918), gives an account of operations performed on 132 patients during the recent spring offensive in the present war. The summary is detailed and his conclusions in substance are as follows: No patient should be operated on until thoroughly warmed unless bleeding is uncontrollable. Patients coming in with a tourniquet, with or without severing of main vessels, are bad risks, as gas gangrene is likely to have developed, and the wound in such cases should never be closed. Any unusual rise of temperature or pulse, especially if associated with restlessness, calls for immediate attention on account of the risk of gas gangrene. Persisting high temperature and pulse almost always mean that the wound is not doing well, unless pneumonia or some other acute systemic condition can be positively shown. Freedom from subsequent infection is directly in proportion to the removal of damaged tissue. Persisting shock

Every-Day Bran Food

Pettijohn's is a morning dish which everybody likes.

Wheat flakes and oat flakes are combined to yield a most delightful flavor.

The 20 per cent bran is in flake form, hidden in the flakes. It is inconspicuous, yet it is efficient.

Doctors told us they wanted a bran dish which people would continue. Now thousands of doctors say that Pettijohn's meets that requirement well.

It is now, we believe, more largely used than any other bran food.

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A Flaked Cereal Dainty

80% Wheat Product Including the Bran — 20% Oats

A breakfast dainty whose flavory flakes hide 20 per cent unground bran.

Pettijohn's Flour — 75 per cent Government Standard flour with 25 per cent bran flakes. Use like Graham flour in any recipe.

Both sold in packages only.

(1941)

usually indicates hemorrhage. Ether has shown an unusual efficacy when employed to lavage wounds during and after operation, especially when muscle tissue is much involved. Post-operative dressings should be moist for the first few days at least. Drainage will cause infection if used for more than forty-eight hours, especially if rubber tubing is employed in parts subjected to movement, such as the abdomen or chest.

———℞———

Tuberculosis Examinations in the Army.

F. B. Trudeau (Saranac Lake, N. Y.), New Haven, Conn. (Journal A. M. A., September 7, 1918), reports his experience in examinations for tuberculosis in training camps at Plattsburg and Camp Devens. He states the lessons that have been taught by experience in this work, namely, the grouping of cases in the history taking as well as in the physical examination itself. He holds that a tuberculosis examining board should occupy only six hours of their time each day in the work, and the number of pulmonary examinations for each medical officer should be at least seventy-five, but should not exceed one hundred. The work is so intensive that it is tiring on both mind and body, therefore, the above time limit is suggested. The routine taking of histories is not of much value, but the one most important procedure in the pulmonary examination is auscultation for rales after cough, performed preferably and if possible at the end of respiration. The disability board to which rejections are referred should consist of three members, the president of the examining board and two others chosen by him from the members of the board. It should have the final disposition of all lung cases referred to it. The average incidence of tuberculosis in the cases examined was 0.5 per cent, slightly lower than in the reserve officers, slightly higher in the National Army, and just this average in the Regular Army.

WANTED — One person Ozone Generator, motor driven. Give full particulars. Dr. W. L. Davis, Corning, Kansas.

LOCATION WANTED—A Captain in the Medical Corps, U. S. A., desires a location in a Kansas town of around 1,000 population or more. Vacancies caused by death, removal or non-return of physician from army considered. Town must have accredited high school, electric lights, and prefer waterworks. Will buy auto, drugs and some fixtures, and lease office and residence. Give full particulars, as business, competition, terms, etc. Address L. B. 17, Reading, Kansas.

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First the grains are toasted by an hour of fearful heat. The moisture inside each food cell is changed to super-heated steam.

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Puffed Wheat and Puffed Rice are whole grains. Corn Puffs are pellets of hominy puffed. All go through this steam-exploding process.

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Sole Makers

Puffed Rice
Puffed Wheat
Corn Puffs

All Steam-Exploded Grains

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For Injuries to the Skin

While it is more generally used in the treatment of burns, it also is employed successfully in the treatment of all injuries to the skin, where, from whatever cause an area has been denuded—or where skin is tender and inflamed — varicose ulcers, granulating wounds of the skin, etc.

Surgeons will find it useful to seal wounds after operations instead of collodion dressings.

It maintains the uniform temperature necessary to promote rapid cell growth.

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